Joe Lombardo
Governor

Rique Robb
Interim Director

DEPARTMENT OF HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION

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

Jessica Adams
Interim Administrator

OFFICE OF COMMUNITY LIVING (OCL) INTAKE
HOME AND COMMUNITY BASED SERVICES APPLICATION

Home and Community Based Services Waiver for Persons with Physical Disabilities (HCBS-PD)
Home and Community Based Services Waiver for the Frail Elderly (HCBS-FE)
Community Service Options Program for the Elderly (COPE)
Personal Assistance Services (PAS)

ADSD OFFICE LOCATIONS AND CONTACT INFORMATION:

CARSON City Office
1550 E College Parkway
Carson City, NV 89706
(775) 687-4210 (main)
(702) 792-0143 (fax)

ELKO Office
1010 Ruby Vista Drive, Suite 104
Elko, NV 89801
(775) 687-0800 (main)
(702) 792-0143 (fax)

LAS VEGAS Office
7150 Pollock Drive
Las Vegas, NV 89119
(702) 486-3545 (main)
(702) 792-0143 (fax)

RENO Office
10375 Professional Circle
Reno, NV 89521
(775) 687-0800 (main)
(702) 792-0143 (fax)

OCL INTAKE STATEWIDE 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.

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.

*** If you need assistance with completing this application, ask a family member, a friend or contact an ADSD local office.**

READ CAREFULLY BEFORE SUBMITTING THIS APPLICATION

- ☐ I understand failure to answer ALL questions on this application may result in delay in processing time. I understand 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.
- ☐ I understand that I must apply for and be determined financially eligible by ADSD for COPE and PAS programs, and by the Division of Welfare and Supportive Services (DWSS) for the HCBS FE and HCBS PD Waivers.
- ☐ I understand that verifications of income and resources will be needed to process the application. Be prepared to obtain these documents promptly upon request.
- ☐ I understand that if I have a Managed Care Organization (MCO), I may want to contact them to understand how applying for Full Medicaid services may affect my MCO services.
- ☐ **APPLICANTS UNDER THE AGE OF 65**: I understand that it is my responsibility to submit Medical Records within 30 days from the date the OCL Application was submitted. I understand medical records must include sufficient evidentiary information to support the reported physical disability that may include Diagnosis, Primary Care Physician office visit notes, medical History and Physical, physical summary, discharge summary or treatment and prognosis.
  - ☐ I understand if I do not meet the financial criteria for HCBS PD Waiver services and choose to apply for the PAS program, I may also be required to provide a statement or an additional form signed and dated by a medical practitioner to confirm the physical disability.

APPLICATION INFORMATION

Name of Applicant (Last, First, Middle)**:**	**Social Security Number:**	**Date of Birth:**	**Age:**

Gender:	**Preferred Language:**	**Ethnicity/Race:**	**Medicaid Number:**	**Veteran or Spouse of Veteran:** ☐ **Yes** ☐ **No**

Marital Status (Choose one)**:**

☐ Divorced ☐ Married ☐ Never Married

☐ Widowed ☐ Separated

Current Living Situation:

☐ Living with Family/Others ☐ Group Home/Assisted Living

☐ Alone

☐ Unhoused ☐ Other:

Physical Address:	**Mailing Address** (If different from physical address)**:**
Primary Telephone Number:	**Email Address:**
Secondary Telephone Number:	**The best time to contact me is:**
Referring Party Name and Relationship:	**Referring Party Telephone Number/Email:**

ADSD will only provide information to the applicant or their verified authorized representative. Please complete the following:

- I choose to assign someone as my authorized representative to speak on my behalf. ☐ Yes ☐ No
- To verify this choice, I understand I must complete and sign the attached Authorization to Release Information form. ☐ Yes ☐ No
- I have a ☐ Power of Attorney (POA) ☐ Guardian ☐ Supported Decision Making Representative ☐ N/A
- To verify this information, I understand I must submit proof to ADSD of the guardianship, POA, or the Support Decision Making Agreement. ☐ Yes ☐ No

Medical diagnoses related to my care needs:	I **am under the age of 65, and I have been diagnosed with a permanent physical disability, AND I am willing and able to submit medical records documenting the physical disability within 30 days of the application being submitted.** ☐ Yes ☐ No ☐ N/A, I am age 65 +

I need help, supervision and /or reminders with at least one of the following activities of daily living: bathing/showering, dressing/undressing, hygiene, toileting, walking/mobility? ☐ Yes ☐ No

I need at least one of any of the following services (check all that apply)**:**

☐ Case Management: support with managing services

☐ Emergency Alert Device: quickly report an emergency or fall

☐ Adult Day Care: socialization, meals, recreation, supervision

☐ Homemaker: laundry, shopping, and light housekeeping services

☐ Companion: companionship/emotional support

☐ Home delivered meals or meal preparation

☐ Respite: short-term break for primary caregiver

☐ Group Home or Assisted Living: 24 hour care

I am currently receiving the following services: ☐ Hospice ☐ Home Health ☐ Personal Care Services ☐ Homemaker ☐ VA Aid & Attendance

	Total Monthly Gross Income (before deductions) ADSD will request verifications.	**Total Resources** (i.e. checking/savings, IRA, 401K, Life insurance policy, burial policy, stocks/bonds, Go Fund Me accounts, land, buildings, trusts, etc…). ADSD will request verifications.
Applicant:	$	$
Spouse:	$	$

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 ommited. 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) _____ Relationship to Applicant _____ Date _____

☐ I, the AR, confirm the individual applying for services is aware this application has been submitted on their behalf.

Aging and Disabilities Services Division

Authorization for Release of Information

If you need help with this form, ADSD staff will help explain it. You can also read the ADSD Notice of Privacy Practices for more information.

Authorization to Share the Aging and Disability Services Division (ADSD) Records of:

Name: Last First Middle **Date of Birth:**

Mailing Address: Number City State Zip Code

Share to:

Name: Last First Middle **Title**:

Name of person, provider, organization, facility or program: (If Applicable)

Address: Number City State Zip Code

Telephone Number: **Fax Number:** **E-mail Address**:

The person giving this permission is related to me as:

☐ My Custodian/Designee/Legal Guardian ☐ Parent ☐ Self

☐ Other (Describe Including First, Last Name):

☐ **I am not asking ADSD to share my records now**. Please place this in my file for future use.

Permission:

I allow the ADSD programs I choose below to share or give access to my private information. Information may be given by secure computer data transfer, fax, in-person, mail, or verbally.

Check the programs you approve below:

☐ ADSD Administration
☐ Adult Protective Services (APS)
☐ Autism Treatment Assistance Program (ATAP)
☐ Communication Access Services (CAS)
☐ Developmental Services (DS)
☐ DS Intermediate Care Facility (ICF)
☐ Nevada Early Intervention Services (NEIS)
☐ Office of Community Living (OCL)
☐ Office of Consumer Health Assistance (OCHA)
☐ Other Approved Program(s) (Specify):

Reason for sharing: ADSD will share records to determine the individual's eligibility and/or to coordinate services. Services, payment, enrollment, or eligibility will not be decided based on the permission to share information, unless the law says differently.

I approve the following ADSD records to be shared or received as checked below:

☐ Assessments
☐ Consultation Reports
☐ Developmental Screeners
☐ Educational Records
☐ Financial Records
☐ Intake Evaluations and Records
☐ Legal Records
☐ Lab/X-Rays/Imaging Studies/Test Results
☐ Medical Information (including but not limited to medical and hospital records)
☐ Progress Notes and Treatment Plans (including but not limited to Individualized Family Support Plan, Care Plans, Person-Centered Service Plans)
☐ Other:

Aging and Disabilities Services Division

Authorization for Release of Information

☐ The following records ONLY:

Consent:

I understand that:

- I can ask for a copy of the privacy rules.
- I do not have to sign this form.
- I can cancel this permission at any time. I must turn in my request in writing to ADSD if I want to cancel my permission.
- ADSD will not share any health information after I end the permission. I know information may have been shared before it was cancelled.
- A copy of this form can be accepted; it does not have to be original.
- If I think I have been treated unfairly because my HIV/AIDS-related information was shared, I can contact the Office of Civil Rights.
- ADSD shares information to make decisions about my services.
- When ADSD shares information based on this release to a recipient, the information may be shared by the recipient and no longer be protected by federal or state law.

I will not hold ADSD employees responsible for sharing information to those listed on this form.

My permission will end:

☐ One (1) year from the date of signature, unless otherwise specified below.

☐ Other:

This permission will automatically end when my case is closed.

Authorized By (Print Last, First Name) **Date**

Authorized By (Signature) **Date**

Signature of ADSD Employee **Date**

What Laws Protect This Information?

- Confidentiality and Consent Requirements for Substance Use Disorder Patient records law is about the privacy of alcohol and drug treatment of patient records (42 CFR 2.31).
- Family Educational Rights and Privacy Act (FERPA) is about privacy of educational or early intervention records (34 CFR 99.30-99.39).
- Laws about the disclosure of mental health information (45 CFR 164.508).
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to protect your health information for treatment, payment, and/or health care operations (45 CFR 164.506).

Privacy and Information Sharing

ADSD has decided not to share information about:

- Drug and alcohol treatment
- HIV/AIDS health information
- Mental health treatment

If someone receives private information, they cannot share it. They also cannot use it without written permission from the person it is about. The only exception to this is whether federal or state law allows it.

Clear Form

Aging and Disabilities Services Division

Authorization for Release of Information

This permission is written consent for information protected by the Family Educational Rights and Privacy Act (FERPA).

Instructions for Completion of Authorization Form

"You" refers to the subject of the records.

Purpose: You should use this form when you want ADSD to be able to share private information about you with another person (including an attorney, a legislator, or a relative). You may give permission to share all confidential records ADSD has about you. You may limit your permission to specific records. You may limit which programs in ADSD can use/share your information. This form will also allow ADSD to talk about your situation verbally or in writing.

Notice to Clients: Most client information ADSD has is private. It will not be shared with others unless you give permission, or if sharing is allowed by law. You can read the ADSD Notice of Privacy Practices for information on how ADSD programs covered by HIPAA share protected health information and your privacy rights. You can also ask the person who gave you this form.

Use: You may fill out this form electronically or on paper. Use the tab key on a computer to move between fields.

A separate form must be completed for each person whose records are requested, including children.

Parts of Form:

Name: Provide your full name or the name of the person whose records are requested if you are acting for someone else. Your full name will help us identify you differently from other people with similar names to yours.

Date of birth: Please tell us when you were born. This will help us identify you in case you have the same name as someone else.

Mailing Address: Provide your full mailing address so information you request can be sent to you.

Share To: Tell ADSD who is allowed to see your records. Please fill out this section with as much information as you can. We will contact the person or organization you have listed. They will have access to your information.

Permission: This says you allow ADSD to send your information in different ways.

ADSD Programs: Please choose the ADSD programs you want to share your records with. Write in the name of program in "Other" if it is not in the list.

Reason for Sharing: This information explains why ADSD is asking to send or receive your records.

ADSD Records to be Shared: Tells us what records that you want shared. You may give permission for all or part of your ADSD client or other confidential records. You may also limit sharing to client records held only by the ADSD programs and records marked in the section above.

Consent: This section tells you about what you should understand if you sign this form. It also explains when your permission will end.

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		

OFFICIAL ELECTION MAIL
Authorized by the U.S. Postal Service

FIRST CLASS STAMP NECESSARY FOR MAILING