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.

Administrator
Dena Schmidt

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
3208 Goni Road, Suite 1-181
Carson City, NV 89706
(775) 687-4210 (main)
(775) 688-2969 (fax)

ELKO Office
1010 Ruby Vista Drive, Suite 104
Elko, NV 89801
(775) 738-1966 (main)
(775) 688-2969 (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)
(775) 688-2969 (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, house, land, buildings, trusts, etc…). ADSD will request verifications.
Applicant:	$	$
Spouse:	$	$

Voluntary Questions: **What sex were you assigned at birth, such as on your original birth certificate?** (Mark one) ☐ Male ☐ Female ☐ Prefer not to disclose	**How do you describe yourself?** (Mark one) ☐ Male ☐ Female ☐ Transgender Man/Transgender Male ☐ Transgender Woman/Transgender Female ☐ Gender queer/gender non-conforming ☐ Prefer not to disclose ☐ Different Identity, Please specify: _____	**Which of the following best represents your sexual orientation identity?** (Mark one) ☐ Straight or Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Prefer not to disclose ☐ Not, listed: Please specify: _____

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.

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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		

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

FIRST CLASS STAMP NECESSARY FOR MAILING