STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

MAABD ONLY REDETERMINATION

RD DATE

CLIENT'S NAME	TELEPHONE	CASE NO.

CLIENT'S ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS

Other than *Medicare/Medicaid*, do you have any other medical/dental insurance? ☐ YES ☐ NO
If YES, please attach a copy of both sides of your insurance card when you return this form.

Have you been injured or involved in an accident in the past twelve (12) months? ☐ YES ☐ NO

Have you had any changes in your income, resources, living situation, or medical expenses since our last contact? ☐ YES ☐ NO
If YES, please explain the change(s):

BANK	RESO	RESOURCES	TRAN	LIFE	PROP

List all resources and income for you and/or your spouse: **(attach verification)**

	TOTAL	LOCATION/HOW MANY?
Patient Trust Fund Account	$	
Money on hand (cash)	$	
Savings account	$	
Checking account	$	
Stocks/Bonds	$	
Life insurance (burial, life)	$	
Burial funds	$	
Other (list type of resource):	$	

Have you transferred or given away any resources? ☐ YES ☐ NO

Have you purchased any annuities? ☐ YES ☐ NO

If YES, give type _____ And amount: $ _____

Transferred to/Purchased: _____ Date transferred/Purchased: _____

Be aware that by virtue of the provision of medical assistance for institutional care, annuities purchased on or after February 8, 2006 must name the State of Nevada as the remainder beneficiary.

JINC	INCOME	OINC	UNIN

	AMOUNT
Social Security benefits	$
Supplemental Security Income (SSI)	$
Retirement/pension	$
Veterans benefits	$
Spouse's income (list type of income):	$
Other (wages, gifts, etc.) (list type of income):	$

RENT	INCOME	SPOUSAL LIVING EXPENSES	UTIL

Shelter expenses (rent, mortgage, taxes, insurance, utilities) List type of expense(s):	AMOUNT
	$
	$
	$

AREP	MEDICAL EXPENSES	MEDX

Insurance premiums (list type of insurance):	TOTAL AMOUNT/VALUE	PAYMENT FREQUENCY
	$	
Client medical bills (not payable by Medicaid):	$	
	$	
	$	

If you have had other changes not described above, please describe them in the area below. If you (or your spouse) are receiving any additional income or resources not listed on this form, please list them below and attach verification. If you want to name an authorized representative (A/R), or you want to name a different person as your A/R, please check this box ☐ . Your case manager will send you a document to record your request. It must be completed and returned before your representative will be acknowledged on your case.

RIGHTS, RESPONSIBILITIES AND PENALTIES

At the time of your application, you signed a copy of your rights and responsibilities. These requirements continue to apply. You may contact your local office for a copy of these provisions.

Federal regulations now require Social Security Numbers (SSNs) for all individuals receiving or seeking to receive assistance for themselves. If you or an individual in your household is applying for assistance and do not wish to provide or apply for an SSN, only this person's request for assistance will be denied. Undocumented or ineligible non-qualified citizens and other non-applicants or ineligible persons are not required to provide or apply for an SSN. SSNs are used to verify your family's income and resources and to conduct computer matching with other agencies such as the Social Security Administration, Employment Security Division, Child Support Enforcement Programs and the Internal Revenue Service. It is also used to gather workforce information, investigations, recover overpaid benefits and to ensure duplicate benefits are not received.

DECLARATION AND SIGNATURE(S)

I/We have read (or had explained to me/us) and understand the information on both sides of this eligibility review form. I/We declare under the penalty of perjury, information I/we gave in this review is true, correct and complete to the best of my/our knowledge.

NOTE: Failure to return this form will affect your eligibility for benefits.

SIGNATURE OF CLIENT	TELEPHONE NUMBER	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	TELEPHONE NUMBER	DATE
CASE MANAGER SIGNATURE		DATE