

**NEVADA STATE DIVISION OF HEALTH
FAMILY HEALTH SERVICES
3427 Goni Road, Suite 108
Carson City, Nevada 89706**

APPLICANT / CLIENT RESPONSIBILITY AGREEMENT

Between applicant / client and the Nevada State Division of Health, FAMILY HEALTH SERVICES, hereafter referred to as FHS:

1. I understand that after I have been told about the decision made by the Health Division regarding my application, if I am not satisfied, I have the right to a fair hearing. If I feel I have been discriminated against because of race, color, sex, religion or national origin, I have the right to file a complaint with the Nevada State Health Division, 505 E. King Street, Room 200, Kinkead Building, Carson City, Nevada 89701-4792.
2. I understand that if I do not assist the Health Division and appropriate authorities the establish paternity and/or to try to seek father's participation in medical costs for his child, I will not be eligible for FHS financial support for medical services.
3. I hereby authorize the Nevada State Health Division to make any investigation concerning me, my dependant and my children's legal parent(s) which is necessary to establish my initial or continued eligibility for assistance. This authorization constitutes a full and complete release from any liability resulting from disclosure of required information to the appropriate authority.
4. I agree to notify the Nevada State Health Division **immediately** when there is any change in my situation that might affect my eligibility for assistance. This would include change in address, name, assets, property, and income or change in income of myself or any member of the household, number of children attending school, number of persons living in the household, change in living arrangements, health insurance, or any other fact that could affect my eligibility for assistance.
5. I understand that approval of the application must be made before care can be provided through FHS. The approval of the application and any financial assistance is dependent upon confirmation that I or my child has an **eligible FHS medical condition** and upon the authorization by myself to permit FHS to investigate my financial status and to determine my **financial responsibility** regarding full/partial/or no payment of any medical costs authorized by FHS in relation to services requested under this application.
6. I understand the determination of an eligible medical condition under FHS may be delayed until the hospitalization is complete and medical records are reviewed by FHS.
7. I realize that I must give complete and accurate information, that I must cooperate with the Division to establish initial and on-going eligibility; and that willful concealment of income and assets could result in criminal prosecution.
8. I agree that if money is awarded from a public fund drive, litigation or settlement, I will advise FHS. Also, I understand that this money is to be used prior to FHS funds toward payment for provider medical services and/or related costs. For services already paid, FHS may require reimbursement. I will keep FHS informed of all steps taken to recover damages, this includes the name of my attorney and dates of any court hearings.
9. I understand and agree that for conditions not covered by FHS **I am liable** to the provider for the entire cost of services.

WHITE – FHS, CANARY – Applicant/Client

10. I agree to abide by any repayment determination.
11. I agree to show my FHS Identification Card to each and every provider of services to the child or myself for whom I am responsible.
12. I agree to notify each and every provider of services of any insurance coverage including CHAMPUS and supply them with the necessary forms. I agree to assign any insurance payments that I receive or am eligible to receive to those providers of care.
13. I understand that failure to apply for recommended prior resources, complying with all required guidelines, will automatically void my FHS application. Also, if accepted into a prior resource program, I agree to advise FHS and all providers of care of this fact.
14. I agree that if EMERGENCY SERVICES are given:
 - a. During normal working hours (8-5, M-F) that FHS is notified by telephone the same day.
 - b. Outside of normal working hours, that FHS is notified by telephone the next working day.
15. I agree to update the application before the expiration date and recognize that failure to do so will result in my termination for FHS eligibility.
16. I agree to notify FHS of the date of scheduled APPOINTMENTS and/or hospitalizations with any physician prior to the date of visit so that this service can be reviewed for possible authorization prior to the date of service.

I have read, or have had read to me, and understand the above agreement. I understand that failure to comply with the agreement stipulations can result in termination of my eligibility from this FHS program. I acknowledge receipt of a copy of this agreement.

Signature of Applicant

Date

Signature of Persons Helping to Complete Form

Date

(Use if applicant cannot read, or write, or is blind)

I have heard the information contained in this application read to the applicant and have witnessed the signature above and witnessed that the applicant received the copy.

WITNESS:

Signature

Date

Address

**IF YOU HAVE QUESTIONS REGARDING THE PAMPHLETS AND FORMS GIVEN TO YOU,
PLEASE ASK YOUR PROGRAM REPRESENTATIVE.**