Nevada Ryan White Parts ABCD
Common Guidance Document
Survey of Existing Insurance Coverage

Client Name: _____ Client DOB: _____

You must make every effort to have and maintain health care coverage. If you are requesting monthly premium or copayment assistance for your health insurance plan, please provide your insurance cards and plan information to Access to Healthcare Network.

Is Health Insurance or Prescription Assistance being requested? ☐**Yes** ☐**No**

1. I Do currently have insurance through my **Employer** as an active employee.

   **If you have an employer plan, you will be given Common Guidance Document (CGD) 15-49.*

2. I Do currently have insurance through Nevada Health Link/Insurance **Marketplace**.

   2b. *I currently do not have insurance and my income is between 139% and 400% of the Federal Poverty Level.

   ☐ **I am declining to apply for Marketplace coverage.** ☐ **I want a referral for Marketplace coverage.**

3. I Do currently have **Medicare Part A/B** (Hospital Insurance/Medical Insurance).

4. I Do currently have a **Retiree Health Plan** from a former employer which includes prescription drug coverage.

5. I Do currently have a **Medicare Part D Plan** (prescription drug coverage).

6. I Do currently have a **Medicare Health Plan** (HMO/PPO/PFFS including prescription drug coverage).

7. I Do currently have **Nevada Medicaid**.

   7b. *I currently do not have insurance and my income is at or below 138% of the Federal Poverty Level.

   ☐ **I am declining to apply for Medicaid coverage.** ☐ **I want a referral for Medicaid coverage.**

8. I Do currently have **Veterans Health Administration** or other military health benefits.

9. I Do currently have **Indian Health Service** or other tribal health benefits.

I hereby declare that the above information regarding my insurance status is true.

_____ _____

Client Signature Date