

**Storey County Health and Community Service Department**

**County Indigent Healthcare Program  
Notice of Ineligibility**

Applicant's Name

Address

City, State, Zip Code

Applicant

Based on the information received by this office, it has been determined that you are ineligible to receive indigent care benefits from Storey County, Nevada at this time. The reasons for denial are listed below:

Reasons for Denial:

- 1.
- 2.
- 3.

Please see the attached supporting documents

If you believe this decision is not correct, you may request a fair hearing within 90 days to appeal this decision. If you have any questions, please complete the information below and contact this office at the address or phone listed at the top of the form.



\_\_\_\_\_  
Storey County Representatives Signature

\_\_\_\_\_  
Date

**REQUEST FOR APPEAL**

**I do wish to appeal this decision of denial.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date