

## **Need Insurance?**

Did you age of foster care at 18? You qualify for Aged Out Medicaid Insurance through the State of Nevada. If you aged out of foster care from Nevada, you may access Aged Out Medicaid until the age of 26. If you aged out of another state NOT Nevada, you may access Aged Out Medicaid until the age of 21.

If you are a young adult who will be leaving foster care soon, talk with your social worker or case worker about signing up so you will have Medicaid health insurance.

***You do not need to go to the Nevada Health Link website to apply unless you are applying for other Welfare services.***

### **How to Enroll:**

- ◆ Contact your IL Service Provider or your social worker or case worker so that they may help you with the process
- ◆ Print a copy of the one page application here or a copy may also be found at: <http://dcfs.nv.gov/Programs/CWS/IL/>
- ◆ Submit copies of your court documents stating that you aged out of foster care, your birth certificate, your social security card and your picture ID.
- ◆ Mail the application and copies of your documents to:

Department of Welfare and Supportive Services  
Carson City District Office  
ATTN: Aging Out Program  
2533 Carson Street #200  
Carson City NV 89706

For questions and more information email [IL@dcfs.nv.gov](mailto:IL@dcfs.nv.gov) or call 775-684-7955

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 DIVISION OF CHILD AND FAMILY SERVICES  
**MEDICAID APPLICATION**  
 Aged Out Foster Care

**PRINT OUT AND COMPLETE FORM**

Please complete this section listing all persons living in the household.

NAME	RELATIONSHIP	RACE/ ETHNICITY	SEX	BIRTHDATE	BIRTHPLACE	SOCIAL SECURITY NUMBER
	<i>self</i>					
Home Address		City		State		Zip
Mailing Address		City		State		Zip
Home Phone				Day/Cell/Message Phone		

If any household member is not a U.S. Citizen, provide the following information:

NAME	ALIEN REGISTRATION NUMBER

Were you in the custody of a child welfare agency on your 18<sup>th</sup> birthday?

- Yes, Date you left foster care: \_\_\_\_\_  
 Public child welfare agency with custody: \_\_\_\_\_
- No

Do you have any medical expenses from the last three months?

- Yes, Month(s) of medical expense(s): \_\_\_\_\_ (attach copy of bill)
- No

Do you have insurance coverage?  No

Yes, Provide policy holder information below and attach a copy of the insurance card.

Policy Holder Last Name: _____	First Name: _____	SSN: _____
Insurance Company Name: _____	Policy #: _____	Group #: _____
Claim Billing Address: _____		Phone #: _____
Policy Holder Employer: _____		
Begin Date of Coverage: _____	End Date of Coverage: _____	
Policy Coverage	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> RX <input type="checkbox"/> Medical <input type="checkbox"/> Well Child Visits <input type="checkbox"/> Hospital	<input type="checkbox"/> Long-Term Care <input type="checkbox"/> Other (specify) _____

If N/A or "Unknown" appears as an answer to any question, please explain:

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I certify that the answers to the questions on this application are complete and accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For Eligibility Office Use Only</b>	
Child is eligible for Medicaid	
<input type="checkbox"/> Yes	Effective Date: _____
<input type="checkbox"/> No	Reason: _____
Eligibility Worker Signature: _____	Date: _____

Please drop off or mail the completed application to: **Department of Welfare and Supportive Services - Carson City District Office, ATTN: Aging Out Program, 2533 N Carson Street #200, Carson City NV 89706**