

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 also applying for other welfare services.

How to Enroll:

- ◆ Contact your Independent Living service provider, your social worker, or your 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 or call 775-684-4444.

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 18th 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: _____ | | End Date of Coverage: _____ | |
| Begin Date of Coverage: _____ | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision | <input type="checkbox"/> RX |
| Policy Coverage | <input type="checkbox"/> Medical | <input type="checkbox"/> Well Child Visits | <input type="checkbox"/> Hospital |
| | | | <input type="checkbox"/> Home Health Care |
| | | | <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:

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

Signature: _____ Date: _____

| | |
|--|-----------------------|
| For Eligibility Office Use Only | |
| 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**