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.
- Click the link to find your local Welfare and Supportive Services Office to mail your application and copies of your documents.

  https://dwss.nv.gov/Contact/Welfare_District_Offices-North/

  https://dwss.nv.gov/Contact/Welfare_District_Offices-South/

For questions and more information email IL@dcfs.nv.gov.

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

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 REGISTRATON 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 _____ Fisrt Name _____ SSN _____
Insurance Company Name _____ Policy # _____ Group # _____
Claim Billing Address _____ Phone # _____
Policy Holder Employer _____
Begin Date of Coverage _____ End Date of Coverage _____
Policy Coverage ☐ Dental ☐ Vision ☐ RX ☐ Hospital ☐ Long-Term Care
☐ Medical ☐ Well Child Visit ☐ Home Health Care ☐ 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 Use Only

Child is eligible for Medicaid

☐ Yes Effective Date: _____

☐ 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**