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 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
	self					
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: _____
Begin Date of Coverage: _____ End Date of Coverage: _____
Policy Coverage ☐Dental ☐Vision ☐RX ☐Hospital ☐ Long-Term Care
☐ Medical ☐ Well Child Visits ☐ 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 compelte and accurate to the best of my knowledge.
Signature: _____ Date: _____

For Eligibility Office 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**