



Operated by:
Clark County Social Service
2820 W. Charleston Blvd. Suite B-15
Las Vegas, Nevada 89102

MEDICAID INFORMATION For Former Foster Youth

Please find enclosed an application for you to continue to receive State Medicaid health insurance coverage after your termination from child welfare custody. You are eligible to receive this assistance as a result of the passage of a new State law in Nevada. This law allows all former foster youth who aged out of foster care at 18 or older to receive Medicaid up until the youth's 21st birthday.

This law was passed to assist you in maintaining good health. You will now be able to see your doctor, dentist, the hospital, or obtain lab tests and medication under this coverage, and will not have to pay the full cost of treatment.

Please complete the application attached after your termination date by the family court, and mail or **bring** it to the address below:

Step-Up Program
Clark County Social Service
2820 W. Charleston Blvd. Suite B-16
Las Vegas, NV 89102

Along with the application you will need:

- 1) Picture Identification**
- 2) Birth Certificate (*certified copy*)**
- 3) Proof of current address**

If you are already receive Medicaid as an SSI recipient, this State coverage will not be necessary and you do not have to complete the application.

Once you have applied, you should hear from the State Medicaid office within about 60 days. When approved, you will receive instructions on how to use your Medicaid and when the coverage begins. If you have not heard from the Medicaid office by this time, please contact your Step-Up case worker for further information, or call the Medicaid hotline at 486-1550.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNv.gov/depts/social_service/

**DIVISION OF CHILD AND FAMILY SERVICES
MEDICAID APPLICATION**

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

No

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"/> Hospital	<input type="checkbox"/> Long-Term Care
	<input type="checkbox"/> Medical <input type="checkbox"/> Well Child Visits <input type="checkbox"/> Home Health 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: _____

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