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? ☐ 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 ☐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 complete 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:
____

If there are question with eligibility due to child welfare custody, contact Shawna Barnes (DCFS)**: 775 684-4442**