JOE LOMBARDO
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

MEDICAL FACILITY INFORMATION

RE: _____ _____
(Name) (Date of Birth)

The following information is necessary to determine the Medicaid eligibility for the above-named individual.

Please provide the information below and return to the above address. Your cooperation will help insure integrity and maintain accountability in the administration of public funds in Nevada. The information provided us will be used only in conjunction with the official duties of this department and will be considered confidential.

If our identifying information (name and birthdate) does not agree with your records, please indicate the change.

1. Does this person currently reside in your facility? ☐ YES ☐ NO

   Level of Care: _____

2. Is this person a County Welfare recipient? ☐ YES ☐ NO

   If YES, what county? _____

3. Latest Admission Date: _____ Discharge Date: _____

4. Current Patient Trust Fund Balance: $ _____ as of (date) _____

5. Lowest Patient Trust Fund Balance for the following months:

Months	Patient Trust Fund Balance

6. All resources and income (Social Security, pensions, etc.) noted on your records: _____

   _____

   Do these checks come to the facility? ☐ YES ☐ NO

7. Names, addresses and telephone numbers of next of kin:

Name	Address	Telephone Number

8. Any medical coverage other than Nevada Medicaid:

Plan Name: _____

Policy Number: _____

Policy Holder: _____

Signature	Print Name	Title/Relationship	Date	Telephone Number