NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

JUSTICE INVOLVED APPLICATION ADDENDUM

ATTESTATION OF ELIGIBILITY FOR RE-ENTRY PROGRAM

(All sections of this form must be completed and submitted to DWSS to allow for re-entry program evaluation)

SECTION 1:

Information in this section **MUST MATCH** the Division of Welfare and Supportive Services (DWSS) and Social Security records. Refer to the individual's Medicaid Card or the DWSS Notice of Decision letter (if available) for more information.

Inmate's Last Name: *(Please Print)*	Inmate's First Name: *(Please Print)*	Middle Name: *(Please Print)*
Social Security Number / Tax ID Number ☐☐☐ - ☐☐ - ☐☐☐☐	Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐	Sex: *(as assigned at birth)* ☐ Male ☐ Female

Inmate's Medicaid Billing Number *(If known)*: ☐☐☐☐☐☐☐☐☐☐☐	Inmate's Current Mailing Address:	City:	Zip Code:

INMATE'S CURRENT MEDICAID STATUS:

☐ None ☐ Suspended ☐ Unknown

SECTION 2: ATTESTATION OF AUTHORIZED SIGNATORY / HEALTHCARE PROFESSIONAL

Information in this section must be completed when submitting this form to DWSS for an evaluation of eligibility.
Complete **Part A** if requesting an inmate be evaluated for a re-entry program.
Complete **Part B** if an inmate in a re-entry program must be returned to suspended Medicaid (if they no longer meet the re-entry program qualification for any reason).

Facility Name: *(Please print)*

☐ MEDICAID RE-ENTRY PROGRAM REQUEST

A. ATTESTATION OF HEALTHCARE PROFESSIONAL FOR QUALIFIED JUVENILE OR INMATE

I certify and attest that the above-named inmate in Section 1 meets the qualifications for a Medicaid re-entry program.
I have indicated the expected release date below for the individual as required to comply with the DWSS re-entry program eligibility policy.

EXPECTED RELEASE DATE ☐☐ / ☐☐ / ☐☐☐☐
(Must be no more than 120 days from today)

☐ MEDICAID SUSPENSION REQUEST

B. ATTESTATION TO RETURN QUALIFIED JUVENILE OR INMATE TO SUSPENDED STATUS

Please remove the above-named individual from the Medicaid re-entry program and return to their suspended Medicaid status as they no longer meet the qualifications for a Medicaid re-entry program. The effective date of this request is indicated below.

SUSPENDED EFFECTIVE DATE ☐☐ / ☐☐ / ☐☐☐☐
(Must be no more than 120 days from today)

SECTION 3: SIGNATURE AND CONTACT INFORMATION

Information in this section must be completed when submitting this form to DWSS for an evaluation of eligibility.
Missing or incomplete information may result in a delay or denial in case processing.

Must include full name and signature of Authorized Signatory/Healthcare Professional. Do not use initials.

Print Name: ______________________ **Title/NPI:** ______________________

Signature: ______________________ **Date:** ______________________

Address: **Phone:**

Disclaimer: Upon release from the public institution, you must provide the address of where you intend to reside. All important documents, such as eligibility determinations, Medicaid card, etc., will be mailed to the last address you provided.

Designation of Authorized Representative

Applicants may designate an individual or facility to act responsibly on their behalf. This includes assisting with the individual's application for assistance, renewals of eligibility and other ongoing communications with the agency. This designation must include the applicant's signature. For a valid designation, the designated authorized representative must also agree in writing to act responsibly on behalf of the applicant/recipient.
The rights and obligations of an authorized representative are the same as if they were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.

Do you want to name an ***individual*** as your authorized representative? ☐ Yes ☐ No **If no**, skip this section.

Name of Authorized Representative:	Phone Number: (_______)_______- _________

Mailing Address: *(Required)*	City:	State:	ZIP Code:

By signing, you agree to allow this person to act and speak on your behalf with all DWSS matters regarding your Medicaid eligibility. This individual will receive copies of all official notifications about your case with DWSS. NOTE: This authorization is only valid for the current Medicaid eligibility period unless you inform DWSS to terminate the authorization sooner.

_______________________________________ ____/____/______

Your Signature: Date:

If you wish to designate a facility as your Authorized Representative, the section below must be completed and signed by the applicant and facility staff member:

I, ____, request the following person/agency:
(PRINT NAME OF APPLICANT/ RECIPIENT) (CIRCLE ONE)

____ to be my:
(PRINT NAME OF PERSON OR AGENCY)

☐ Primary representative (Receives all requests for information along with any attachments plus all notices. They hold the same responsibility as the customer in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the customer. Primary representatives have the same access to case information as a customer.)

☐ Secondary representative (Receives the same requests for information and notices as the customer but are not responsible for securing or reporting information; however, if they choose to, they may secure and report the requested information to the DWSS. A secondary representative has the same access to case information as a customer, but cannot sign on behalf of the customer.)

I understand I may terminate this designation in writing at any time and that the authorization for the facility to act as an authorized representative ceases upon release from the public institution.

____

SIGNATURE OF APPLICANT DATE OF BIRTH DATE

STATEMENT OF DESIGNATED FACILITY REPRESENTATIVE

I believe the above-named applicant/recipient understands the nature and consequences of his/her acts and is able to exercise his/her own will. I certify the above-named applicant/recipient made the decision to designate me as his/her representative under no threat or duress of any kind.

☐ As primary representative, I agree to act responsibly on behalf of the above-named applicant/recipient by providing all necessary information to determine eligibility for assistance. I understand my rights and obligations are the same as if I were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.

☐ As secondary representative, I understand I will receive all notifications regarding the above-named applicant/recipient's initial and ongoing eligibility and may provide any information to assist in the eligibility process. **I understand I have no authority to sign on behalf of the above-named applicant/recipient.**

I certify under penalty of perjury; the information I provide is correct and complete to the best of my knowledge.

____

SIGNATURE OF REPRESENTATIVE (PRINT NAME) POSITION/RELATIONSHIP DATE

____

ADDRESS TELEPHONE NUMBER

____

NAME OF JUSTICE INVOLVED FACILITY

INSTRUCTIONS FOR FORM 2971-EE (02/25), "JUSTICE INVOLVED APPLICATION ADDENDUM" - English

PURPOSE

This form is completed by a carceral facility or their authorized signatory/healthcare professional as an addendum to the Medicaid Application for Justice Involved Individuals, Form 2970. This form will serve as the attestation of the carceral facility/signatory or healthcare professional that the listed inmate qualifies for a re-entry program or that the inmate no longer qualifies for a re-entry program based on criteria specified in NRS 422.272428.

INSTRUCTIONS

Carceral facilities or their authorized signatory or healthcare professional must complete all sections of Form 2971-EE.

Section 1 of the form is used to identify the inmate by their full name, SSN/Tax ID, Date of Birth, Sex (as assigned at birth) and the inmate's Medicaid billing number (if known/applicable), current mailing address, and current Medicaid status (if known).

Section 2 of the form is used to identify the carceral facility name and will indicate the attestation from the facility/signatory or healthcare professional that the identified inmate in section 1 either qualifies for a re-entry program evaluation with a release date within the next 120 days, or that a re-entry approved inmate must be removed from the re-entry program within the next 120 days and returned to suspended status.

In Section 2, select either A. or B. based on the stated circumstances.

Section 3 of the form is used to gather the signature and contact information of the facility/signatory or healthcare professional completing the form. Please complete all fields thoroughly. Missing or incomplete information may result in a delay in processing while the missing information is requested for completion.

Please submit the completed addendum to DWSS via:
Email: Justicemed@dwss.nv.gov
Fax: 702-631-3387

Page 2 "Designation of Authorized Representative" Form

This page is *optional and should only be completed when the applicant wishes to designate an individual or the carceral facility as an authorized representative.

Completion of this form communicates the intent of the applicant to authorize an individual or the carceral facility to act on behalf of the incarcerated individual for the purpose of Medicaid eligibility.

If the applicant designates ***an individual*** as an authorized representative, additional steps must be taken by DWSS before the designation becomes valid. The DWSS will need to send an Authorized Representative Form 2525 to the designated individual listed on the form, with a request for the designated individual to return the completed Form 2525 indicating their agreement in writing to act responsibly on behalf of the applicant. The completed Form 2525 signed by the authorized representative is required for the designation to be valid. It is imperative for the applicant to provide a valid mailing address for the designated authorized representative.

If the applicant designates ***the carceral facility*** as an authorized representative, the carceral facility representative must also complete and sign in the section labeled "STATEMENT OF DESIGNATED FACILITY REPRESENTATIVE". When completed, this is considered a valid designation. It should be noted that this

Designation of Authorized Representative Form will cease upon release from the public institution.
Be sure to select the appropriate box to indicate whether the authorized representative will be a primary or secondary representative. The applicant must sign, provide the applicant's date of birth, and include the date the form was signed.

"Statement of Designated Representative" section to be completed by designated carceral facility staff member with name (Print legibly), position title, and date. All facility information including address and telephone number must also be provided.

Ensure all information is legible.

***For a minor child, aged 17 or younger, when a parent or guardian is not available to sign and submit an application on behalf of the minor child who is incarcerated, the carceral facility has the authority to complete and submit the application AND Designation of Authorized Representative form on behalf of the minor.**