

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)

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SECTION 1: Information in this section MUST MATCH the Refer to the individual's Medicaid Card or the DV	**	· · · · · · · · · · · · · · · · · · ·
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:
INMAT	E'S CURRENT MEDICAID STATUS:	<u> </u>
☐ None	Suspended	Unknown
Information in this section must be completed who Complete Part A if requesting an inmate be evalued Complete Part B if an inmate in a re-entry program program qualification for any reason).	nated for a re-entry program.	
Facility Name: (Please print)		
I certify and attest that the above-named inmate in I have indicated the expected release date below policy.	PROFESSIONAL FOR QUALIFIED JUVE a Section 1 meets the qualifications for a Medic for the individual as required to comply with t	aid re-entry program.
EXPECTED RELF (Must be no more than 120 a		
MEDICAID SUSPENSION REQUIDED. B. ATTESTATION TO RETURN QUAL Please remove the above-named individual from no longer meet the qualifications for a Medicaid results of the suspension of the sus	THED JUVENILE OR INMATE TO SUSPI the Medicaid re-entry program and return to the e-entry program. The effective date of this requ FIVE DATE	eir suspended Medicaid status as they
SECTION 3: SIGNATURE AND CON Information in this section must be completed who Missing or incomplete information may result in a	en submitting this form to DWSS for an evaluat	tion of eligibility.
Must include full name and signature of Authorized Signatory/Hea	lthcare Professional. Do not use initials.	
Print Name:	Title/NPI:	
Signature:	Date:	
Address:	Phone:	
Disclaimer: Upon release from the public institution documents, such as eligibility determinations, Medical determinations of the public institution of the public instituti		

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? \square Yes \square No If no, skip this section. Phone Number: Name of Authorized Representative: Mailing Address: (Required) City: State: 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: , request the following person/agency: (PRINT NAME OF APPLICANT/ RECIPIENT) 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 reentry 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.