NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
KINSHIP CARE PROGRAM

The Kinship Care Program provides children living with a Non-Parent, Relative Caregiver a TANF benefit amount and some supportive services.

Specific eligibility requirements for Kinship Care include:

- You must be 62 years of age or older; and
- The parent(s) of the child(ren) are not living in the home; and
- The child(ren) you are caring for must have been under your care for at least six (6) months; and
- Proof you are related to the child(ren) by blood or marriage; and
- Having obtained Nevada state or tribal legal guardianship and comply with the requirements imposed by the court.

A gross income test of 275% of the Federal Poverty Level for the household size that includes the child(ren) is applied for and all adults and children with a relationship (by blood or marriage) to the child(ren) applied for must be met. If the gross countable income is at or below 275%, only the child(ren)'s income is used to determine eligibility and payment. If the gross income exceeds 275%, the child(ren) is ineligible for assistance.

All other TANF program requirements must be met. You may receive Child-Only TANF benefits as a Non-Parent relative caregiver, if eligible, until eligibility is determined under Kinship Care. If you are receiving Child-Only TANF assistance and then qualify for Kinship Care assistance, the Kinship Care benefit amount will be effective the first month after the month all Kinship Care eligibility requirements are met. When approved for Kinship Care, the TANF Child-Only assistance will be terminated.

SUPPORT SERVICES

Kinship Care recipients may be eligible for the following services related to the care of the child(ren):

- Transportation;
- Respite care;
- Referrals to community organizations depending on need of service.

I understand that if the Division of Welfare and Supportive Services (DWSS) later discovers I made a false or misleading statement, misrepresented, concealed or withheld facts to establish or maintain program eligibility, my benefits may be reduced/terminated. I am responsible for repayment of all monies, services and benefits for which I was not entitled. Additionally, I understand I may be disqualified from program participation, criminally prosecuted or otherwise penalized according to applicable state and federal laws.

By signing this form, I choose to apply for Kinship Care assistance.

Customer's Signature	Case Manager's Signature
Case UPI Date	Telephone Number Date