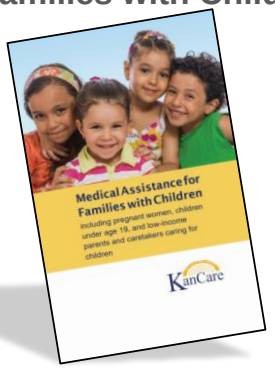
A Guide to Completing the KC-1100 Application

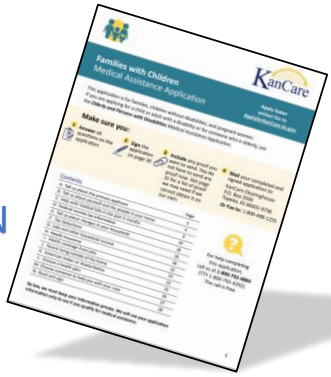
A Guide to Completing the KC-1100 Application

For Families with Children



KanCare

Sections L, M, & N



This guide was created in partnership with the KanCare Ombudsman Office and the Kansas Department of Health and Environment.

2

"Welcome to the KanCare Application Guide. This guide is made up of slides designed to help you with filling out the sections of Families with Children Application"

Page 26: KC-1100: Choose a Health Plan

L. Choose a health plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please read the *Extra Services Highlights* flyer that came with this application. Then choose your plan. We will only use the health plan information if you qualify for coverage.

If **you** choose, we will enroll you in that plan if you qualify for KanCare. If you do **not** choose, a plan will be assigned for you. If you do not like your assignment, you will have 90 days to change plans. You will receive a packet of information about your plan. To learn more about the plans, visit www.KanCare.ks.gov.

If you do **not** qualify for a KanCare plan, you will get information about other coverage and services separately.

Choose a health plan for each person. The plans can be the same or different.

If you have more than 6 people in your household, make a copy of this page before you fill it out. Attach the copy to your application.

Person 1	Person 2	Person 3
First and last name	First and last name	First and last name
☐ aetna (Aetna Better Health of Kansas)	☐ aetna (Aetna Better Health of Kansas)	☐ aetna (Aetna Better Health of Kansas)
☐ sunflower health plan	☐ sunflower health plan	☐ sunflower health plan
☐ UnitedHealthcare	☐ UnitedHealthcare	☐ UnitedHealthcare

Person 4	Person 5	Person 6
First and last name	First and last name	First and last name
☐ aetna (Aetna Better Health of Kansas)	☐ aetna (Aetna Better Health of Kansas)	☐ aetna (Aetna Better Health of Kansas)
☐ sunflower health plan	☐ sunflower health plan	☐ sunflower health plan
☐ UnitedHealthcare	☐ UnitedHealthcare	☐ UnitedHealthcare

KC1100 121

3

This is the twenty-sixth page of the paper application for Families with Children. Page 26, Section L, is where the applicant will choose a health plan for each person listed on the application applying for medical assistance.

Choosing a health plan

Pg.26

L Choose a health plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please read the *Extra Services Highlights* flyer that came with this application. Then choose your plan. We will only use the health plan information if you qualify for coverage.

If **you** choose, we will enroll you in that plan if you qualify for KanCare. If you do **not** choose, a plan will be assigned for you. If you do not like your assignment, you will have 90 days to change plans. You will receive a packet of information about your plan. To learn more about the plans, visit www.KanCare.ks.gov.

If you do **not** qualify for a KanCare plan, you will get information about other coverage and services separately.

4

The top of page 26 provides more information about choosing a health plan. It says, “Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please read the Extra Services Highlights flyer that came with this application. Then choose your plan. We will only use the health plan information if you qualify for coverage. If you choose, we will enroll you in that plan if you qualify for KanCare. If you do not choose, a plan will be assigned for you. If you do not like your assignment, you will have 90 days to change plans. You will receive a packet of information about your plan. To learn more about the plans, visit www.kancare.ks.gov. If you do not qualify for a KanCare plan, you will get information about other coverage and services separately.

You can also find the Extra Services Highlights on the kancare.ks.gov website under consumers/benefits and services. The applicant can also narrow down which health plan is a good fit for them by contacting their current providers and asking which health plans they have a contract with. This will prevent the applicant from having to change providers if they are found eligible for KanCare services. To find more information on how to choose a health plan please refer to the Additional KanCare Resources link in the guide series. Look for the Selecting-Changing an MCO resource.

Choosing a health plan

Pg.26

Choose a health plan for each person. The plans can be the same or different.

If you have more than 6 people in your household, make a copy of this page before you fill it out. Attach the copy to your application.

Person 1	Person 2	Person 3
First and last name	First and last name	First and last name
☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas
☐ sunflower health plan	☐ sunflower health plan	☐ sunflower health plan
☐ UnitedHealthcare	☐ UnitedHealthcare	☐ UnitedHealthcare

Person 4	Person 5	Person 6
First and last name	First and last name	First and last name
☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas
☐ sunflower health plan	☐ sunflower health plan	☐ sunflower health plan
☐ UnitedHealthcare	☐ UnitedHealthcare	☐ UnitedHealthcare

5

The next part of page 26 is where the applicant will check which health plan each person applying for medical assistance wants to provide benefits and services if eligible.

If there are more than 6 people in the applicant's household applying for medical assistance, make a copy of this page before filling it out, and attach the copy to the application.

Page 27: KC-1100: Someone Helping with Your Case

M If you have someone to help you with your case

If you have someone to help you with your case, that person can also be your **Medical Representative** or **Facilitator**. You will choose a date below for a Facilitator's help to end.

If you choose to have a **Medical Representative**, that person can:

- Help you complete the application
- Make decisions about your case
- Get copies of letters about your case during **and** after the application process
- Talk with KanCare about your case
- Use your medical card to request services for you
- Request a fair hearing about your case and represent you at the hearing
- **Not** be someone who is trying to collect a medical debt against you or be an employee of a nursing facility

If you choose to have a **Facilitator**, that person cannot help you make decisions about your case. You will be in charge of your case. Your Facilitator can:

- Help you complete the application
- Get copies of letters and information during the application process, or for up to one year

I choose this person to help as my: ☐ **Medical Representative** ☐ **Facilitator**

First and last name | Organization name (if any)

Address | City | State | ZIP Code

Phone number | Email address

This person is my (parent, friend, lawyer, etc.):

▶ If you choose a Facilitator, how long do you want this person to help with your case? Check one.

☐ During the application process or for 6 months, whichever is later

☐ Until 1 year after the date I sign this application on **page 30**

☐ Until (mm/dd/yyyy) ____/____/____
(cannot be longer than 1 year unless Facilitator is your parent, child or attorney)

Guardian, Conservator, Financial Power of Attorney or Social Security Payee

▶ If you are a guardian, conservator, financial power of attorney or Social Security payee completing this application for someone, tell us your information below. You must also send proof.

First and last name

Address | City | State | ZIP Code

Phone number | Email address

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free. **27**

#

6

This is the twenty-seventh page of the paper application for Families with Children. Page 27, Section M, is where the applicant can choose a Medical Representative or Facilitator. Now let's go through each section on page 27.

Choosing an Authorized Representative

Pg.27

M If you have someone to help you with your case

If you have someone to help you with your case, that person can also be your **Medical Representative** or **Facilitator**. You will choose a date below for a Facilitator's help to end.

If you choose to have a **Medical Representative**, that person can:

- Help you complete the application
- Make decisions about your case
- Get copies of letters about your case during **and** after the application process
- Talk with KanCare about your case
- Use your medical card to request services for you
- Request a fair hearing about your case and represent you at the hearing
- **Not** be someone who is trying to collect a medical debt against you or be an employee of a nursing facility

If you choose to have a **Facilitator**, that person cannot help you make decisions about your case. You will be in charge of your case. Your Facilitator can:

- Help you complete the application
- Get copies of letters and information during the application process, or for up to one year

I choose this person to help as my: ☐ **Medical Representative** ☐ **Facilitator**

First and last name	Organization name (if any)
Address City State ZIP Code	
Phone number	Email address
This person is my (parent, friend, lawyer, etc.):	

▶ If you choose a Facilitator, how long do you want this person to help with your case? Check one.

☐ During the application process or for 6 months, whichever is later

☐ Until 1 year after the date I sign this application on **page 30**

☐ Until (mm/dd/yyyy) _____/_____/_____
(cannot be longer than 1 year unless Facilitator is your parent, child or attorney)

7

If the applicant has someone to help them with their case, that person can also be the applicant's Medical Representative or Facilitator.

If the applicant chooses to have a Medical Representative, that person can help them complete the application, make decisions about their case, get copies of letters about the case during and after the application process, talk with us about the case, use the medical card to request services for the applicant, request a fair hearing about the case and represent the applicant at the hearing. The Medical Representative cannot be someone who is trying to collect a medical debt against the applicant or be an employee of a nursing facility.

If the applicant chooses to have a Facilitator, that person cannot help make decisions about the applicant's case. The applicant will be in charge of their application and case. The Facilitator can help complete the application and get copies of letters and information during the application process. Please select one of the three options for how long the applicant wants the facilitator to help with their case. The Facilitator appointment cannot be longer than 1 year unless it is the applicant's parent, child, or attorney.

The applicant must sign the application on page 30 to designate the medical representative or facilitator roles appointed on page 27.

Choosing an Authorized Representative

Pg.27

Guardian, Conservator, Financial Power of Attorney or Social Security Payee			
▶ If you are a guardian, conservator, financial power of attorney or Social Security payee completing this application for someone, tell us your information below. You must also send proof 🔗.			
First and last name			
Address	City	State	ZIP Code
Phone number	Email address		

8

If there is a financial power of attorney, conservator, or legal guardianship, please provide the name and contact information here. The applicant can also mail or fax the proof of power of attorney, conservatorship, or legal guardianship to us.

The application cannot be processed until this documentation is received.

Page 28-29: KC-1100: Read and Sign

N Read and sign

Before you send your application, you must sign and date it on **page 30**.
Please read the information below. Then **sign and date** in the spaces provided.

I understand:

- I have the right to equal treatment regardless of race, color, national origin, age, disability, sex, religion or political belief.
- Federal law does not allow discrimination based on race, color, national origin, age, disability or sex. I can file a discrimination complaint at https://khap2.kdhe.state.ks.us/kfmam/civilrightscomplaint.asp.
- I have the right to have information I provided kept private unless directly related to the administration of Kansas medical assistance programs.
- Some or all of the people I am applying for may get similar health coverage under the Medicaid program if they qualify.
- I have the responsibility to use and report any third-party resources such as health insurance, court settlements, medical support payments, trusts, conservatorships, etc. that may be legally obligated to pay any or all of the medical expense of people I am applying for. I understand that payment for a particular service may be withheld while a determination of failure to use a third-party resource is made.
- Any payments made to me by a third-party resource for medical services covered under Kansas medical assistance programs will be used to pay for the applicable medical bills and that these programs will only pay for services not covered by that third-party resource. I agree to cooperate with the medical subrogation unit in pursuing those third-party resources.
- If I receive medical assistance after age 54 or while in an institution, there may be a claim against my estate to recover the medical expenses paid for me. I understand that my financial institution will be notified of a pending claim.
- I have the responsibility to read and truthfully answer all the questions on this application. I understand that if I give false or purposefully misleading information on this application or hide information requested by the application, I will be subject to penalties for my actions.
- I have the right to ask for a fair hearing if I disagree with an agency decision or I think they did not follow all federal and state rules.
  - The office must get my hearing request within **33** days of the date on the decision notice.
  - I can ask for the hearing by phone or mail:

    Phone: **1-800-792-4884** (TTY 1-800-792-4292), **or**

    Mail: The Office of Administrative Hearings
    1020 S. Kansas Ave
    Topeka, KS 66612
- I can represent myself at the hearing or I can have someone represent me. The hearing decision usually comes within 90 days of the request date.
- If I have an urgent medical need, I can ask for an expedited (fast) hearing:
  - I must send a medical professional's proof of the need with my request.
  - If approved, an expedited hearing will be scheduled as soon as possible.
  - If denied, the hearing will be scheduled in the usual time.

KC1100 R15

N Read and sign *(continued)*

- I have to provide or apply for a Social Security Number (SSN) for anyone who is applying for health benefits and I authorize use of the SSNs to administer the program. The SSNs will also be used for computer matches with other organizations such as banks, the Social Security Administration and Internal Revenue Service.
- I am responsible to give correct income, address and household composition information, and to report changes during the application process and while I am eligible.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household qualify for medical assistance.
- To help Child Support Services (CSS) establish and enforce needed support orders if adults in the household qualify for medical assistance.
- To pay the Children's Health Insurance Program (CHIP) premium each month if I qualify for that program. The premium can be as low as $0 or as much as $50, depending on my income.

I certify:

- That everyone I am requesting health coverage for who qualifies for coverage is a U.S. citizen, U.S. national, or non-U.S. citizen in lawful immigration status. Proof of immigration status may be required.
- Under penalty of perjury, that my answers are correct and complete to the best of my knowledge.

I authorize:

- Payments under this program to be made directly to the doctors and other medical providers or managed care organizations for covered medical and other health services.
- Medical providers to release medical information to:
  - Kansas Department of Health and Environment, Division of Health Care Finance (KDHE)
  - Department for Children and Families (DCF)
  - Kansas Department for Aging and Disability Services (KDADS)
  - U.S. Department of Health and Human Services
  - Insurance companies
  - Other contracted medical providers
- KDHE, DCF, and KDADS to share medical information for administrative purposes with other agencies and contractors.
- Banks, credit unions, and all other financial institutions to release my **financial information** to KDHE, DCF, KDADS or other benefit programs to find if I qualify. I allow this until my application is denied, my eligibility ends, or I end the permission in writing. If I refuse to give or I end this permission, my application may be denied or I may no longer qualify.
- The groups below to release my **private information** to KDHE, DCF, KDADS or other benefit programs to find if I qualify:
  - Employers
  - Medical providers
  - Insurance providers
  - Benefit providers
  - Other persons or agencies as needed

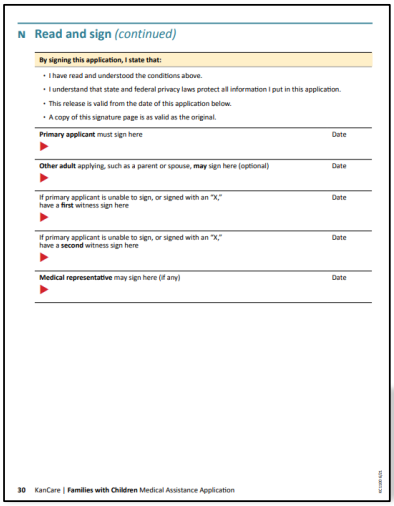
For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

Section N is labeled "Read and Sign".

Read all of the information on pages 28 and 29 carefully so that the applicant understands the agreements they are signing.

When the applicant has finished reading these pages, continue to page 30.

Page 30: KC-1100: Read and Sign



N Read and sign *(continued)*

By signing this application, I state that:

- I have read and understood the conditions above.
- I understand that state and federal privacy laws protect all information I put in this application.
- This release is valid from the date of this application below.
- A copy of this signature page is as valid as the original.

Primary applicant must sign here — Date

Other adult applying, such as a parent or spouse, **may** sign here (optional) — Date

If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here — Date

If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here — Date

Medical representative may sign here (if any) — Date

30 KanCare | **Families with Children** Medical Assistance Application

KC-1100-EN

10

This is page 30 of the paper application for Families with Children. The application must be signed for it to be considered a valid application. The KanCare Clearinghouse may have to reach out to the applicant to obtain your signature, potentially causing a delay in processing. The KanCare Clearinghouse is not able to process an unsigned application.

Now, let's talk about some important points about the signature page.

Read and sign

Pg.30

N Read and sign *(continued)*

By signing this application, I state that:

- I have read and understood the conditions above.
- I understand that state and federal privacy laws protect all information I put in this application.
- This release is valid from the date of this application below.
- A copy of this signature page is as valid as the original.

Primary applicant must sign here	Date
Other adult applying, such as a parent or spouse, **may** sign here (optional)	Date
If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here	Date
If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here	Date
Medical representative may sign here (if any)	Date

If the primary applicant is applying for themselves, their spouse, or a dependent child, please sign the Primary applicant row.

Read and sign

Pg.30

N Read and sign *(continued)*

By signing this application, I state that:

- I have read and understood the conditions above.
- I understand that state and federal privacy laws protect all information I put in this application.
- This release is valid from the date of this application below.
- A copy of this signature page is as valid as the original.

Primary applicant must sign here — Date

Other adult applying, such as a parent or spouse, **may** sign here (optional) — Date

If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here — Date

If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here — Date

Medical representative may sign here (if any) — Date

If there is a second person in the household applying, such as a spouse, they may sign the Other adult applying row. This is optional.

Read and sign

Pg.30

N Read and sign *(continued)*

By signing this application, I state that:

- I have read and understood the conditions above.
- I understand that state and federal privacy laws protect all information I put in this application.
- This release is valid from the date of this application below.
- A copy of this signature page is as valid as the original.

Primary applicant must sign here — Date

X

Other adult applying, such as a parent or spouse, **may** sign here (optional) — Date

If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here — Date

If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here — Date

Medical representative may sign here (if any) — Date

If the primary applicant signed by a mark, such as an x, because they are unable to sign their own name due to illiteracy or disability, then signatures of two witnesses are required. The witnesses will need to sign on the first and second witness lines. The KanCare Clearinghouse may also need contact information for the witnesses such as phone numbers and addresses. These may be requested later if the information is not already known to the KanCare Clearinghouse.

Read and sign

Pg.30

N Read and sign *(continued)*

By signing this application, I state that:

- I have read and understood the conditions above.
- I understand that state and federal privacy laws protect all information I put in this application.
- This release is valid from the date of this application below.
- A copy of this signature page is as valid as the original.

Primary applicant must sign here	Date
Other adult applying, such as a parent or spouse, **may** sign here (optional)	Date
If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here	Date
If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here	Date
Medical representative may sign here (if any)	Date

In order to avoid delays in the application being processed, the primary applicant or a previously authorized representative must sign page 30 of the application.

If the person signing the application is the authorized representative, the KanCare Clearinghouse will need designation of the assignment signed by the primary applicant or authorized representative or someone appointed by the court for it to be considered valid. Designation are (but not limited to): Durable or Financial Power of Attorney, Guardianship, and Conservatorship. It does not include Medical Power of Attorney.

If the medical representative signs page 30 without proof of authorized designation, proof will be required before the application will be processed. This may cause delays in the application being processed and could potentially change the application date.

Page 31: KC-1100: List of Proof

List of proof

This is a list of proof we may need. You do not have to send proof now. We will try to obtain this proof through other means. We may contact you later for this proof if we cannot obtain it on our own.

Proof of income

- **If you are self-employed**
  We may ask you to send copies of all pages and attachments of your most recent personal and business income tax returns.
- **If you have a job**
  We may ask you to send copies of your pay stubs for the last 30 days or a statement from your employer with your gross income before deductions.
- **If you have other income**
  We may ask you to send a copy of the check or benefit letter with the income amount and how often you get the payment.
- **If you want help with unpaid medical bills from the past 3 months**
  We may ask you to send copies of all pay stubs or checks your family has received in the past 3 months.

Proof of health insurance

- **If you are reporting that someone in the household has other health insurance**
  We may ask you to send a copy of the front and back of your insurance card.

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

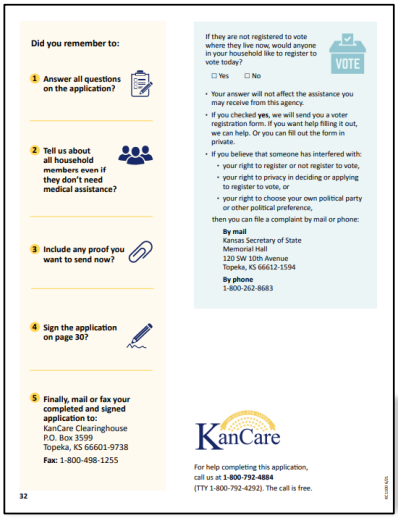
31

15

This is page 31 of the paper application for Families with Children.

This is a list of proof the KanCare Clearinghouse may need. The applicant can send their proof with the application so we can process it faster, but the applicant does not have to send any proof right now. We will try to obtain this proof through other means. The KanCare Clearinghouse will contact the applicant later for this proof if we cannot obtain it on our own.

Page 32: KC-1100: List of Proof



Did you remember to:

1. Answer all questions on the application?
2. Tell us about all household members even if they don't need medical assistance?
3. Include any proof you want to send now?
4. Sign the application on page 30?
5. Finally, mail or fax your completed and signed application to:
   KanCare Clearinghouse
   P.O. Box 3599
   Topeka, KS 66601-9738
   Fax: 1-800-498-1255

32

If they are not registered to vote where they live now, would anyone in your household like to register to vote today?

☐ Yes ☐ No

VOTE

- Your answer will not affect the assistance you may receive from this agency.
- If you checked **yes**, we will send you a voter registration form. If you want help filling it out, we can help. Or you can fill out the form in private.
- If you believe that someone has interfered with:
  - your right to register or not register to vote,
  - your right to privacy in deciding or applying to register to vote, or
  - your right to choose your own political party or other political preference,

  then you can file a complaint by mail or phone:

  By mail
  Kansas Secretary of State
  Memorial Hall
  120 SW 10th Avenue
  Topeka, KS 66612-1594

  By phone
  1-800-262-8683

KanCare

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

KC-1100 9/21

16

This is page 32 of the paper application for Families with Children.

The right side of the page asks, "Would anyone in your household like to register to vote?". If the applicant marks "Yes", a voter registration form will be sent to them. Please mark "No" if they do not want a voter registration form mailed to them.

Before turning in the application, let's review the reminder list on the left side of this page.
Review the application to double check that all questions have been answered.

Make sure all household members are on the application even if they don't need medical assistance.

Review page 31 and gather any proof that the applicant wants to send now. The KanCare Clearinghouse will request proof that they need later so don't let this delay turning in the application.

Double check page 30 to ensure that the application is signed.
Finally, mail or fax the application and any proof that the applicant chooses to send to the KanCare Clearinghouse.

The application can be mailed to P.O. Box 3599 Topeka, KS 66601-9738 or faxed to 1-800-498-1255.

A case worker may call the applicant for additional information while processing the application. A letter requesting additional information or proof may be sent to the applicant and any authorized individuals such as Medical Representatives. A letter will be sent explaining benefits once the application has been processed and a determination made.

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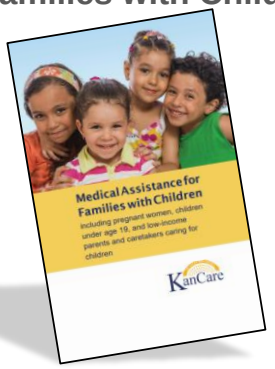
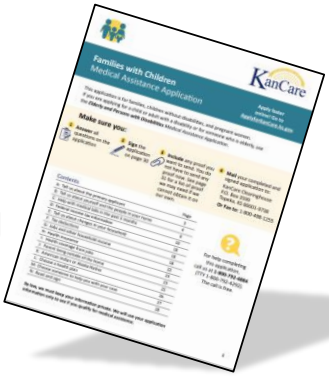
For Families with Children



KanCare

Conclusion L, M, & N



This guide was created in partnership with the KanCare Ombudsman Office and the Kansas Department of Health and Environment.

Thank you for viewing sections L, M, & N.