

KanCare Ombudsman Liaison Training



- KanCare Application Process – FAQs
- A Guide to Completing a KanCare Application

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Application for Medical Assistance for the Elderly and Persons with Disabilities

1	Who can use this application?	This application is for the elderly and persons with disabilities applying for medical assistance. It is not intended to be used for families with children or pregnant women.
2	Apply faster online	GO! Would you rather apply online? Apply faster online at www.applyforKancare.ks.gov
This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form.		
3	Medical Assistance	Medical Assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay for medical and hospital bills, doctor's visits, medicine, Medicare premiums, in-home assistance services, nursing home and institutional care.
4	Medically Needy (Spenddown)	This program is for elderly and disabled persons who live in the community. Based on income level, some individuals are responsible for a portion of their medical expenses (spenddown) before coverage begins.
5	Working Healthy	This program is for disabled or blind persons between the ages of 16 to 64 who are working. Based on income level, some individuals are required to pay a monthly premium.
6	Home and Community Based Services (HCBS)	This program is for persons who have a medical need for services in the community which can keep them out of an institution. There are currently 7 different HCBS programs, each with a different set of rules. Based on income level, some individuals are responsible for a portion of the cost of their care.
7	Nursing Home or Other Facility	This category of coverage is for children and adults residing in a nursing home, medical or mental health institution or similar facility for a long term stay. Based on income level, some individuals are responsible for a portion of the cost of their care in the facility.
8	Program of All-Inclusive Care for the Elderly (PACE)	This program is for disabled persons (age 55 years or older) and persons age 65 or older residing in selected counties within the state. Individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Based on income level, some individuals are responsible for a portion of the cost of their care.
9	Medicare Savings Program (Medicare Costs)	This program is for people who have Medicare and helps with some of the costs. This program pays the Medicare Part B premiums and may also pay Medicare co-payments and deductibles.
		Agency Use Only
		Outstationed Worker <input type="checkbox"/>

For help completing this application, call toll free: 1-800-392-6888

Line-by-Line KanCare Application Guide (Elderly & Persons with Disabilities):

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Application FAQs

1. How do I apply for KanCare?
2. Where do I send my Application?
3. What if I have questions while I am completing the application?
4. How do I check the status of my application?

Application FAQs

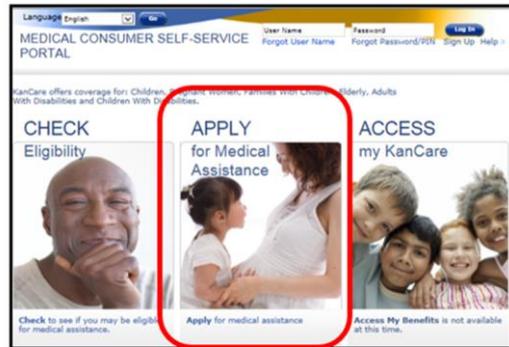
5. What is the ***average wait time*** for an application to process?
6. What can I do if I have been waiting longer than the average time for my application to process?
7. How will I be notified that I have been approved or denied KanCare health coverage?
8. What if I am denied KanCare services?

Two Ways to Apply

2 Types of Paper Applications



ONE [On-line Application](#)



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Paper Applications:

- a. Application for Families with Children
 - children under 19
 - families with children under 19
 - pregnant women
- b. Application for the Elderly and Persons with Disabilities
 - Elderly (65 and older)
 - Persons with Disabilities (child or adult)

Clarification on Children under 19:

A child under 19 will use the Families with Children application if applying for regular Medicaid or CHIP. However, if they are applying for the Medically Needy program, Nursing Facility Program, or for an HCBS waiver program, they'll use the Elderly and Persons with Disabilities application.

On-line Application:

There is only one on-line application. The on-line application is intuitive and changes depending on the data that is entered by each applicant; it will work for all of the possible KanCare programs. URL: www.kancare.ks.gov/consumers/apply-for-kancare

Where do I Send my Paper Application?

Mail or fax your KanCare Application (along with other documentation) to the KanCare Clearinghouse:

Mail to:

KanCare Clearinghouse

PO BOX 3599

Topeka, KS. 66601-9738



Fax To:

- Fax for Families and Children Department: 1-800-498-1255
- Fax for Elderly or Disabled Department: 1-844-264-6285

What if my case is more Complicated or Urgent?



- Fax or mail a letter explaining the details of your case, to the Clearinghouse (with your application and other documentation).
- Follow up with a phone call to the Clearinghouse (2-3 days later) to confirm receipt of your submitted application and documentation.

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Fax To:

1. Fax for Families and Children Department: 1-800-498-1255
2. Fax for Elderly or Disabled Department: 1-844-264-6285



Mail to:

Kancare Clearinghouse
PO BOX 3599
Topeka, KS. 66601-9738



What if an applicant has questions on the application?



- They can call KanCare Clearinghouse customer service at 800-792-4884.
- The KanCare Clearinghouse will also assist in completing the application in-person at their Topeka, KS location (at Forbes Field). They accept walk-ins, though appointments are preferred.
- If an applicant wants assistance completing the application, they can also call the KanCare Ombudsman's office at 855-643-8180 (in-person or over the phone).

Who else assists with KanCare applications?



**KanCare Ombudsman Liaison
Application Assistance Guide**

If your organization provides Application Assistance for Medicaid consumers, please let us know. It may be easier for a consumer to reach your office than ours or vice versa. If your office does NOT provide Application Assistance, please refer those applicants to the KanCare Ombudsman office at 1-855-643-8180 or to one of the organizations on this referral list. Let's work together to reach more Kansans in need!

Organization (Contact Person)	Contact Information	County (City)	Address	Office Hours and Appointment Info	Type of Application
KanCare Ombudsman, Olathe satellite office (Lisa Churchill)	1-855-643-8180	Johnson County (Olathe, KS)	Catholic Charities Building 333 E Poplar St Olathe, KS 66061	*By appointment *In-Person & Phone Assistance Available	Medicaid Applications
KanCare Ombudsman, Wichita satellite office (Tawnya Kitt)	1-855-643-8180	Sedgwick County (Wichita, KS)	Community Engagement Institute 238 N Mead St Wichita, KS	*By appointment *In-Person & Phone Assistance Available	Medicaid Applications
Score 1 for Health from Kansas City University of Medicine and Biosciences (Alex Martinez)	816-654-7972	Wyandotte County (Kansas City)	1750 Independence Ave Kansas City, MO 64106	*In-Person appointments available *Mobile appointments also available: We can also meet you in a community space that is still private enough to do the application.	Medicaid Application for Families with Children (only)
Lane County Health Department (Crystal Hoffman)	620-397-2809	Lane County (Dighton, KS)	125 West Long Dighton, KS 67839	*By appointment	Medicaid Applications
Trego County Hospital (Mary Sothern)	785-743-2182, ext. 278	Trego County (Wakenoey, KS 67672)	320 N 13 th Street Wakenoey, KS 67672		Medicaid Application for the Elderly & Persons with Disabilities (only)

- Check out the [Application Assistance Guide](#) for more locations.
- This guide lists several community organizations that assist KanCare applicants.

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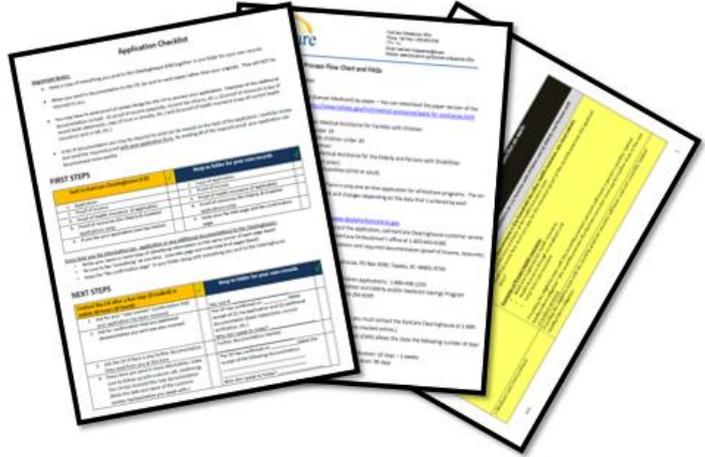
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Does your office provide application assistance?



- If so, please consider adding your information to this guide.
- If you do not provide application assistance, please refer the applicant to the KanCare Ombudsman office at 1-855-643-8180 or to one of the organizations on this guide.
- Let's work together to reach more Kansans in need!

Application Assistance Folder



Application Assistance Folder



The KanCare Ombudsman has created a folder to help new applicants:

- Keep their application and additional documentation organized.
- Know how to follow up after they have submitted their application.
- Answer some frequently asked questions about the application process.

The 1-Page Application Checklist



Application Checklist	
Important Notes:	
<ul style="list-style-type: none"> Keep a copy of everything you send to the Clearinghouse (CH) together in one folder for your own records. When you send in documentation to the CH, be sure to send copies rather than your originals. They will NOT be returned to you. You may have to send proof of certain things for the CH to process your application. Examples of this additional documentation include: (1) proof of income (paystubs, income tax returns, etc.), (2) proof of resources (copy of recent bank statements, copy of trust or annuity, etc.), (3) proof of health insurance (copy of health insurance card and bill, etc.) and (4) proof of disability. A list of documentation you may be required to send can be viewed on the back of the application. Carefully review and send the required proof with your application form. By sending all of the required proof, your application can be processed more quickly. 	
FIRST STEPS	
Send to KaiCare Clearinghouse (CH)	Keep in folder for your own records
1. Application	1. Copy of application
2. Proof of income	2. Proof of income
3. Proof of health insurance (if applicable)	3. Proof of health insurance (if applicable)
4. Proof of resources (for Elderly & Disabled applications only)	4. Proof of resources (for Elderly & Disabled applications only)
5. Proof of disability (or disability application; or appeal of disability denial) (if applicable)	5. Proof of disability (if applicable)
Extra time you fax information (ex. application or any additional documentation) to the Clearinghouse: <ul style="list-style-type: none"> Write your name or some type of identifying information on the same corner of each page faxed. Be sure to fax "everything" at one time. (Use title page and note total # of pages faxed) Keep the "fax title page" which shows how many pages were going to be faxed and the "fax confirmation page/receipt" in your folder along with everything you sent to the Clearinghouse. 	
NEXT STEPS	
Contact the CH after a few days (if mailed) or within 48 hours (if faxed)	Keep in folder for your own records
1. Ask for your "case number" (confirmation that your application has been received)	My case # _____
2. Ask for confirmation that any additional documentation you sent was also received.	The CH has confirmed on _____ (date) receipt of (1) my application and (2) additional documentation (bank statements, income verification, etc.) Who did I speak to today? _____
3. Ask the CH if there is any further documentation they need from you at this time.	Further documentation needed: _____
4. Every time you send in more information, make sure to follow up with a phone call, confirming the CH has received this new documentation (Note the date and name of the customer service representative you speak with.)	The CH has confirmed on _____ (date) the receipt of the following documentation: _____ Who did I speak to today? _____

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1. Reminds you which additional information needs to be submitted with the application.
2. Reminds you to keep a copy for your own records.
3. Provides a place for you to write important dates and information.
4. Tells you what you need to do **after** you have submitted your application!

Keep Copies of Everything

Application Checklist

Important Notes:

- Keep a copy of everything you send to the Clearinghouse (CH) together in one folder for your own records.
- When you send in documentation to the CH, be sure to send copies rather than your originals. They will NOT be returned to you.
- You may have to send proof of certain things for the CH to process your application. Examples of this additional documentation include: (1) proof of income (paystubs, income tax returns, etc.), (2) proof of resources (copy of recent bank statements, copy of trust or annuity, etc.), (3) proof of health insurance (copy of health insurance card and bill, etc.) and (4) proof of disability.
- A list of documentation you may be required to send can be viewed on the back of the application. Carefully review and send the required proof with your application form. By sending all of the required proof, your application can be processed more quickly.

FIRST STEPS

Sent to KanCare Clearinghouse (CH)	Keep In folder for your own records
1. Application	1. Copy of application
2. Proof of income	2. Proof of income
3. Proof of health insurance (if applicable)	3. Proof of health insurance (if applicable)
4. Proof of resources (for Elderly & Disabled applications only)	4. Proof of resources (for Elderly & Disabled applications only)
5. Proof of disability (or disability application; or appeal of disability denial) (if applicable)	5. Proof of disability (if applicable)

Extra time you fax information (ex. application or any additional documentation) to the Clearinghouse:

- Write your name or some type of identifying information on the same corner of each page faxed.
- Be sure to fax "everything" at one time. (Use title page and note total # of pages faxed)
- Keep the "fax title page" which shows how many pages were going to be faxed and the "fax confirmation page/receipt" in your folder along with everything you sent to the Clearinghouse.

NEXT STEPS

Contact the CH after a few days (if mailed) or within 48 hours (if faxed)	Keep In folder for your own records
1. Ask for your "case number" (confirmation that your application has been received)	My case # _____
2. Ask for confirmation that any additional documentation you sent was also received.	The CH has confirmed on _____ (date) receipt of (1) my application and (2) additional documentation (bank statements, income verification, etc.) Who did I speak to today? _____
3. Ask the CH if there is any further documentation they need from you at this time.	Further documentation needed: _____
4. Every time you send in more information, make sure to follow up with a phone call, confirming the CH has received this new documentation. (Note the date and name of the customer service representative you speak with.)	The CH has confirmed on _____ (date) the receipt of the following documentation: _____ Who did I speak to today? _____

- Keep a copy of everything you send to the KanCare Clearinghouse together in one folder for your own records.
- When you send in documentation to the Clearinghouse, be sure to send copies rather than your originals. They will not be returned to you.

Send proof of what you claim on the application:

Application Checklist

Important Notes:

- Keep a copy of everything you send to the Clearinghouse (CH) together in one folder for your own records.
- When you send in documentation to the CH, be sure to send copies rather than your originals. They will NOT be returned to you.
- You may have to send proof of certain things for the CH to process your application. Examples of this additional documentation include: (1) proof of income (paystubs, income tax returns, etc.), (2) proof of resources (copy of recent bank statements, copy of trust or annuity, etc.), (3) proof of health insurance (copy of health insurance card and bill, etc.) and (4) proof of disability.**
- A list of documentation you may be required to send can be viewed on the back of the application. Carefully review and send the required proof with your application form. By sending all of the required proof, your application can be processed more quickly.

FIRST STEPS

Send to KaiCare Clearinghouse (CH)	Keep in folder for your own records
1. Application	1. Copy of application
2. Proof of income	2. Proof of income
3. Proof of health insurance (if applicable)	3. Proof of health insurance (if applicable)
4. Proof of resources (for Elderly & Disabled applications only)	4. Proof of resources (for Elderly & Disabled applications only)
5. Proof of disability (or disability application; or appeal of disability denial) (if applicable)	5. Proof of disability (if applicable)

Every time you fax information (ex. application or any additional documentation) to the Clearinghouse:

- Write your name or some type of identifying information on the same corner of each page faxed.
- Be sure to fax "everything" at one time. (Use title page and note total # of pages faxed)
- Keep the "tax title page" which shows how many pages were going to be faxed and the "tax confirmation page/receipt" in your folder along with everything you sent to the Clearinghouse.

NEXT STEPS

Contact the CH after a few days (if mailed) or within 48 hours (if faxed)	Keep in folder for your own records
1. Ask for your "case number" (confirmation that your application has been received)	My case # _____
2. Ask for confirmation that any additional documentation you sent was also received.	The CH has confirmed on _____ (date) receipt of (1) my application and (2) additional documentation (bank statements, income verification, etc.) Who did I speak to today? _____
3. Ask the CH if there is any further documentation they need from you at the time.	Further documentation needed: _____
4. Every time you send in more information, make sure to follow up with a phone call, confirming the CH has received this new documentation (Write the date and name of the customer service representative you speak with.)	The CH has confirmed on _____ (date) the receipt of the following documentation: _____ Who did I speak to today? _____

Depending on which program you apply for, and what you claim on the application, you may need to send some additional documentation:

1. Proof of Income
2. Proof of Health Insurance
3. Proof of Representative
4. Proof of Resources/Assets
5. Proof of *Pending* Disability Case with SSA (if applicable)
6. Proof of Expenses
7. Proof of Immigration Status (for eligible non-citizens)

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Why do they need "Proof of Expenses?"

1. In instances where consumers owe a monthly Client Obligation or Patient Liability, or a Spenddown, submitting receipts for medically necessary costs that were NOT covered by Medicaid or other insurance may reduce the amount they owe.
2. If you have a disability and are working, you may have "work expenses" that impact your eligibility.
3. If the applicant wants coverage for care in a Nursing Facility, Assisted Living Facility, an HCBS waiver program or PACE and has a spouse or "dependent family members," they must provide verification of reported "shelter expenses" (rent or mortgage, property taxes, Home Owner's Insurance and Home Owner's Association Fees).

How do I find out what documentation I need to provide?

Application Checklist

Important Notes:

- Keep a copy of everything you send to the Clearinghouse (CH) together in one folder for your own records.
- When you send in documentation to the CH, be sure to send copies rather than your originals. They will NOT be returned to you.
- You may have to send proof of certain things for the CH to process your application. Examples of the additional documentation include: (1) proof of income (paystubs, income tax returns, etc.), (2) proof of resources (copy of recent bank statements, copy of trust in assets, etc.), and (3) proof of health insurance (copy of current health insurance card/ID card).
- A list of documentation you may be required to send can be viewed on the back of the application. Carefully review and send the required proof **with your application form**. By sending all of the required proof, your application can be processed more quickly.

FIRST STEPS

Send to KanCare Clearinghouse (CH)	Keep in folder for your own records
1. Application	1. Copy of application
2. Proof of income	2. Proof of income
3. Proof of health insurance (if applicable)	3. Proof of health insurance (if applicable)
4. Proof of resources (for Children & Unemployed applications only)	4. Proof of resources (for Children & Unemployed applications only)
5. If you file your application late fee form(s)	5. Keep your fee ID# page and fee confirmation page

Doing Next may be information (on, application or any additional documentation) to the Clearinghouse:

- Write your name or some type of identifying information on the same corner of each page listed.
- Be sure to file "separately" at one time. (Use 100-page and extra hold of paper bound)
- Keep the "fee confirmation page" in your folder along with everything you send to the Clearinghouse.

NEXT STEPS

Contact the CH after a few days of receipt or within 48 hours of receipt	Keep in folder for your own records
1. Ask for your "case number" confirmation that your application has been received.	My case #
2. Ask for confirmation (written or verbal) documentation you send was also received.	The CH has confirmed on _____ (date) receipt of (1) my application and (2) additional documentation (bank statements, income verification, etc.) We do I speak to today?
3. Ask the CH if there is any further documentation they need from you at this time.	Further documentation needed: _____
4. Every time you send in more information, make sure to follow up with a phone call, confirming the CH has received the new documentation (include the date and name of the customer service representative you speak with).	The CH has confirmed on _____ (date) the receipt of the following (or conversation): _____ We do I speak to today?

- Check out the [Documentation Checklist for the KanCare Application](#).
- Carefully review and submit the required documentation along with your application form.
- By sending all of the required documentation, your application can be processed more quickly.

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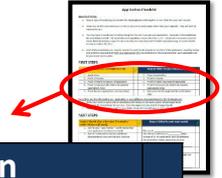
- Documentation Checklist URL:
<http://www.kancare.ks.gov/docs/default-source/KanCare-Ombudsman/resources/documentation-checklist-for-kancare-applications.pdf?sfvrsn=2>

Keep a Very Close Eye on the Mailbox



- If other items are needed by the eligibility team, you will be notified by mail.
- However, the need to request more information will delay application processing time. So send as much as you can with your initial application.
- **Very important:** The requests for more documentation that come by mail have deadlines.
- If applicants do not submit required documentation by those deadlines, they may need to reapply.

First Steps



Sent to KanCare Clearinghouse		Keep in folder for your own records	
1. Application	✓	1. Copy of application	✓
2. Proof of income		2. Proof of income	
3. Proof of health insurance (if applicable)		3. Proof of health insurance (if applicable)	
4. Proof of resources (for Elderly & Disabled applications only)		4. Proof of resources (for Elderly & Disabled applications only)	
5. Proof of <i>pending</i> disability case with the SSA (if applicable)		5. Proof of <i>pending</i> disability case at the Social Security Administration (if applicable)	

Every time you fax to the Clearinghouse:



- Include a cover letter explaining what is being faxed and why, and how many pages.
- Be sure to fax everything at one time, as much as possible.
- Keep the fax receipt in your folder along with everything you've sent to the Clearinghouse.
- If they have difficulty locating your faxed documents, use the information from fax receipt to help them find it.
 - Date and Time of fax
 - Phone # faxed from and phone # faxed to

After You've Submitted the Application



Contact the CH after a few days (if mailed) or within 48 hours (if faxed):	✓	Keep in folder for your own records	✓
Ask for your case number (confirmation that your application has been received)		My case #: _____	
Ask for confirmation that any <i>additional documentation</i> you sent was also received.		The CH has confirmed receipt of the following documents: (bank statements, income verification, etc.) Who did I speak to today? _____	
Ask the CH if there is any further documentation they need from you.		Further documentation needed: _____	
Every time you send more information, follow up with a phone call, confirming the CH has received this new documentation (Note call details).		The CH has confirmed the receipt of the following documentation: _____ Who did I speak to today? _____	

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Stay in contact with the Clearinghouse to make sure they've received your application and the documentation you've sent them. Document everything.

Continue to follow up to see if they need further documentation from you, while your application is in the processing phase.

Issue we see often: When the Clearinghouse needs more documentation from an applicant/member, they will generate a letter and send it to the address that has been provided (which is sometimes out of date, or the individual may not open the mail in a timely manner). By the time the applicant actually reads this letter, they may have lost out on several days of processing time and possibly missed a deadline that will require them to reapply.

Following up with a the Clearinghouse to make sure they have all the documentation they need from you (and have your most updated address) allows you to get in front of this issue.

KanCare Clearinghouse Automated Menu

- Many calls we receive are from callers who are frustrated with the [Clearinghouse Automated Voicemail Menu](#).
- There is not a menu option for all individual needs.
- There is not a direct menu option to reach a customer service representative.
- The next few slides show some of the tips and shortcuts the Ombudsman office uses when communicating with the Clearinghouse.

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Callers will often give up because they cannot get through to someone at the Clearinghouse.

You can use the transcribed *Clearinghouse Voicemail Menu* to help you get to where you need to go quickly.

URL: <http://www.kancare.ks.gov/docs/default-source/KanCare-Ombudsman/resources/kancare-clearinghouse-voicemail-menu.pdf?sfvrsn=2>

Short Cut to Elderly & Persons with Disabilities Department (3-1-3)

- Dial the Clearinghouse toll free number. Wait until after the **language options** have passed and the voice menu starts talking again, then press **3**.
- Wait for more talking, then press **1**.
- Wait for more talking, then press **3**.
- You should hear, “Thank you, I’ll route you to an agent who can help you.” Or, “Please hold, and you will be connected with the next available representative.”

Short Cut to Families with Children Department (2-1)

- Dial the Clearinghouse toll free number.
- Wait until after the **language options** have passed **and** the voice menu starts talking again, then press **2**.
- Wait for more talking, then press **1**.
- You should hear, “Thank you, I’ll route you to an agent who can help you.” Or, “Please hold, and you will be connected with the next available representative.”

No Button Approach

Approximately 5 minute wait. Could be longer during high call volume hours:

- Just listen, and do nothing. If you listen to the menu options **approximately five times**, they will automatically connect you to a customer service representative.
- If that representative cannot answer your question, they will transfer you to someone who can.

Hold Times Too Long?

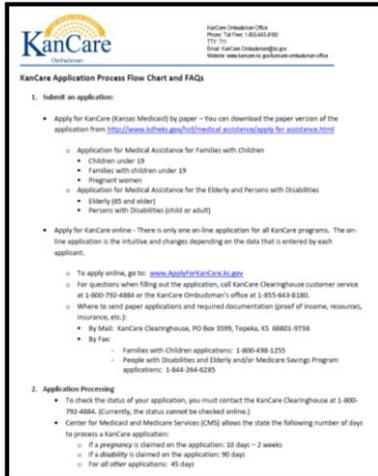
- Individuals may also try calling the Clearinghouse **after 5 p.m.**
- The Clearinghouse doors close at 5 p.m., but they continue to take calls through 7 p.m.
- Callers may find a shorter waiting time during these periods.

Waiting on Hold Tips:

- If you get stuck in a loop, while you are holding, that forces you to leave a message rather than allowing you to continue to hold for a customer service representative, dial: 00 (zero twice).
- This will take you out of that loop, and allow you to continue holding. We always recommend that the caller wait to speak to a representative instead of leaving a message and waiting for a return call.

Application Process Flow Chart

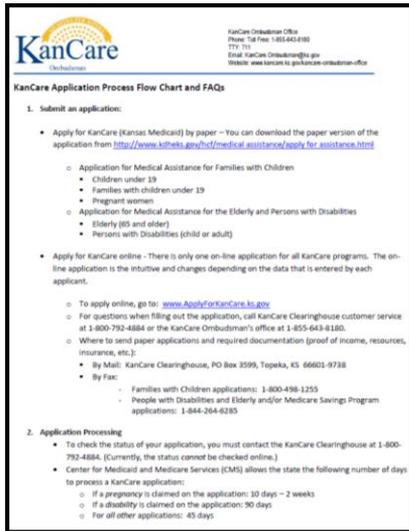
This resource provides a beginning to end guide for new KanCare applicants.



Submitting an Application:

- 2 ways to file an application (paper and online) and provides the necessary links, phone numbers and address.
- Who to call for application assistance (phone or in-person).
- Where to send the application.

Application Process Flow Chart



Application Process:

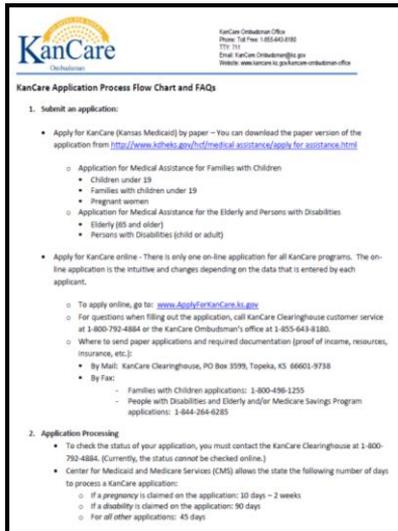
- How do I check the status of an application?
- How long does it take to process an application?
- What should I watch for in the mail? What notices and deadlines do I need to be aware of?
- What if I [don't have health insurance right now](#), but I need medical assistance?

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URL for Assistance for People who are Uninsured:

<http://www.kancare.ks.gov/docs/default-source/KanCare-Ombudsman/resources/assistance-for-those-without-insurance-or-high-spend-down.pdf?sfvrsn=20>

Application Process Flow Chart



The screenshot shows the top portion of a document titled "KanCare Application Process Flow Chart and FAQs". It includes the KanCare logo and contact information for the KanCare Enrollment Office. The main content is organized into two numbered sections: "1. Submit an application:" and "2. Application Processing".

KanCare Enrollment Office
Phone: 1-800-443-8185
TTY: 711
Email: KanCare.Enrollment@ks.gov
Website: www.kancare.ks.gov/kancare-enrollment-office

KanCare Application Process Flow Chart and FAQs

1. Submit an application:

- Apply for KanCare (Kansas Medicaid) by paper – You can download the paper version of the application from <http://www.kshhs.gov/hcf/medical-assistance/apply-for-assistance.html>
 - Application for Medical Assistance for Families with Children
 - Children under 19
 - Families with children under 19
 - Pregnant women
 - Application for Medical Assistance for the Elderly and Persons with Disabilities
 - Elderly (65 and older)
 - Persons with Disabilities (child or adult)
- Apply for KanCare online - There is only one on-line application for all KanCare programs. The on-line application is the intuitive and changes depending on the data that is entered by each applicant:
 - To apply online, go to: www.ApplyForKanCare.ks.gov
 - For questions when filling out the application, call KanCare Clearinghouse customer service at 1-800-792-4884 or the KanCare Enrollment office at 1-855-643-8185.
 - Where to send paper applications and required documentation (proof of income, resources, insurance, etc.):
 - By Mail: KanCare Clearinghouse, PO Box 2999, Topeka, KS 66601-9738
 - By Fax:
 - Families with Children applications: 1-800-456-1255
 - People with Disabilities and Elderly and/or Medicare Savings Program applications: 1-844-264-0235

2. Application Processing

- To check the status of your application, you must contact the KanCare Clearinghouse at 1-800-792-4884. (Currently, the status cannot be checked online.)
- Center for Medicaid and Medicare Services (CMS) allows the state the following number of days to process a KanCare application:
 - If a pregnancy is claimed on the application: 30 days – 2 weeks
 - If a disability is claimed on the application: 90 days
 - For all other applications: 45 days

Notification:

- How will I find out if I am approved or denied?
- What can I do if I am denied, and I believe that is a mistake?

More Frequently Asked Questions:

- What can I do if I feel I have been waiting too long for my application to process?
- If I just need a denial letter for Marketplace, what can I do?

Application Assistance Folder is Available Online



KanCare Applications and Assistance

1. Children and Families Applications (scroll to bottom of web page)
2. Elderly and Disabled Applications (scroll to bottom of web page)
3. Medicare Savings Program Application (scroll to bottom of web page)
4. Application Assistance Guide - Where to Find Help with Medicaid Applications
5. Application Assistance Folder
 - Application Checklist
 - Documentation Checklist for KanCare Applications
 - Application Process and Frequently Asked Questions

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URL for *Application Assistance Folder*:

<http://www.kancare.ks.gov/kancare-ombudsman-office/resources>

How do I check my application status?

KanCare Clearinghouse
1-800-792-4884



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- The process is the same whether you apply on-line or on paper.
- To check the status of your KanCare application you must contact the KanCare Clearinghouse.

The CH's automated system will give you the following three options:

1. You may stay on the line to speak with a customer representative.
2. You may leave a message and they will return your call.
3. You may choose to type in your SSN and birthdate to check the status of your application.

How long does it take for an application to process?



How long until I find out I am eligible?



Center for Medicare and Medicaid Services (CMS) allows the state the following number of days to process a KanCare application:

- 45 calendar days
- **Exception:** If applicant has claimed disability on the KanCare application, but has a **pending** disability case with Social Security: 90 calendar days
- **To help avoid delays:** Applicants should watch for requests (by mail) for more or updated information, so that KDHE Eligibility Team can process your application to completion.

Watch for Requests for More Information



- The KanCare Clearinghouse may send a letter asking for additional information, which is required to process your application.
- Not turning in the documentation requested in a timely fashion will cause delays in application processing.
- Watch for deadlines on the letters. A missed deadline may cause a denial in services.

Applicants Waiting Too Long



- If someone applied for KanCare and they feel they have been waiting too long...
- Find out the date they applied (get approximate date if they don't know).
 - If they have been waiting less than days allotted by CMS, explain to them about the normal processing time.

For applicants waiting over the number of days allotted by CMS:



- Make sure the applicant has confirmed with the Clearinghouse (CH) that all of their required documentation has been received.
- If the CH has confirmed all required documentation has been received, and the application is still “pending” past the days allotted by CMS, the applicant may then request a state fair hearing.

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Clearinghouse Contact:

Phone:

1-800-792-4884

Mail to:

Kancare Clearinghouse
PO BOX 3599
Topeka, KS. 66601-9738

State Fair Hearing:

If you would like to learn more about this option, please contact the KanCare Ombudsman at 1-855-643-8180

How will I be notified whether I have been approved or denied for KanCare services?



Notification

The person who applied will be notified by letter if their application has been approved or denied.



In the meantime, to check on status updates of your KanCare application you must contact the KanCare Clearinghouse at:
1-800-792-4884

What if I am denied, and believe it was due to a mistake?

- **Option 1:** If you contact the KanCare Clearinghouse (1-800-792-4884) and let them know that you feel there was an issue with the processing of the application, they may **Review** the application again. If any issues are found, they will be corrected, and they'll resubmit application for **Redetermination**.
- **Option 2:** You may request a **State Fair Hearing**. If you would like to learn more about this option, please contact the KanCare Ombudsman office at: 1-855-643-8180.

When to Request a State Fair Hearing?

- An application or renewal denial letter will also note that the applicant or member has the option to a hearing if they feel they have cause.
- The reasoning (and supporting documentation) for a hearing would need to show the individual was denied (or not renewed) because the state did not follow the rules in processing the application, rather than show reasons why a person needs KanCare.

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Eligibility Fair Hearing Process URL:

https://www.kancare.ks.gov/docs/default-source/kancare-ombudsman/appeals-state-fair-hearings-grievances/eligibility/eligibility-fair-hearing-process.pdf?sfvrsn=30ff4c1b_2

A Guide to Completing a KanCare Application



For the Elderly and Persons with Disabilities

A few themes to address before one begins this process.



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1. Certain things you claim on the application **must** be backed up (additional documentation).
2. If someone is in your household, they **must** be on the application.
3. Fill out **everything**. Don't leave anything blank.

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Additional Documentation

Documentation Checklist

Documentation Checklist for KanCare Applications	
<small>Please remember to send documentation WITH THE APPLICATION as proof of anything you claimed on the application form. If other items are needed by the eligibility team, you will be notified, however, the need to request more information will delay processing time.</small>	
<small>What type of documentation should I send with my application?</small>	
<small>Families with Children Applications:</small>	<small>Elderly & Persons with Disabilities Applications:</small>
<small>1. Proof of Health Insurance (page 1)</small>	<small>1. Proof of Health Insurance (page 2)</small>
<small>2. Proof of Income (pages 2-3)</small>	<small>2. Proof of Income (pages 2-3)</small>
<small>3. Proof of Representative (pages 9-10)</small>	<small>3. Proof of Resources and Assets (pages 4-6)</small>
	<small>4. Proof of Expenses (page 7)</small>
	<small>5. Proof of Disability (if applicable) (page 8)</small>
	<small>6. Proof of Representative (pages 9-10)</small>
Did you claim any of these on your application? (Please submit proof of these items you claimed.)	
Examples, Definitions and Specifics on each:	
Proof of Health Insurance: Needed for both the Application for Medical Assistance for (1) Families with Children and (2) Elderly and Persons with Disabilities.	Examples of Private Health Insurance:
<small>1. Provide health insurance cards, front and back and a bill as proof of monthly premium paid.</small>	<small>*Providing the eligibility team with the monthly premium amounts will lower a person's monthly "out-of-pocket liability/client obligation" (the monthly premium the KanCare customer must pay for his/her share in the cost of medical services).</small>
	<small>*Providing the eligibility team with the monthly premium amounts will lower a person's monthly "out-of-pocket liability/client obligation."</small>
<small>2. Medicare Card, front and back</small>	

- In order to process your application, KDHE will also need proof of certain things you claimed on the application.
- You must be willing and able to provide this [additional documentation](#).
- By sending all of the required proof up front, your application can be processed more quickly.

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There is still the possibility of more information being requested. So watch your mailbox closely.

If they do not receive the documentation required from you, they cannot process your application fully.

This may include:

1. Proof of Income
2. Proof of Resources/Assets
3. Proof of Health Insurance
4. Proof of Pending Disability (if applicable)
5. Proof of Expenses
6. Proof of Representative

Report Everyone in the Household

- If someone is in your household, they must be on the application, even if they are not applying for insurance.
- If they are not applying for insurance, the information you give on them may be very basic.

C. Tell us about Yourself and the People in your home

List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
--	-------------------	----------	----------

Don't Leave Anything Blank

Did you remember to:

- Fill everything out?
- Tell us about everyone in your family and household, even if they don't need medical assistance?
- Sign this application on page 15?

- Fill out **everything**.
- If something does not apply to the applicant, do not leave it blank.
- Put N/A (not applicable) clearly so that the Eligibility Team knows this does not have to be investigated further.

Page 1, Application for Elderly & Persons with Disabilities

 Application for Medical Assistance for the Elderly and Persons with Disabilities	
Who can use this application?	This application is for the elderly and persons with disabilities applying for medical assistance. It is not intended to be used for families with children or pregnant women.
Apply faster online	GO! Would you rather apply online? Apply faster online at www.applyforKanCare.ks.gov
This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form.	
Medical Assistance	Medical Assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay for medical and hospital bills, doctor's visits, medicine, Medicare premiums, in home assistance services, nursing home and institutional care.
On page 3 of this application you will be asked to indicate the type of help you want for each member of your household. The definition of each type of coverage is listed below. Please refer to these when answering.	
Medically Needy (Spenddown)	This program is for elderly and disabled persons who live in the community. Based on income level, some individuals are responsible for a portion of their medical expenses (spenddown) before coverage begins.
Working Healthy	This program is for disabled or blind persons between the ages of 16 to 64 who are working. Based on income level, some individuals are required to pay a monthly premium.
Home and Community Based Services (HCBS)	This program is for persons who have a medical need for services in the community which can keep them out of an institution. There are currently 7 different HCBS programs, each with a different set of rules. Based on income level, some individuals are responsible for a portion of the cost of their care.
Nursing Home or Other Facility	This category of coverage is for children and adults residing in a nursing home, medical or mental health institution or similar facility for a long term stay. Based on income level, some individuals are responsible for a portion of the cost of their care in the facility.
Program of All-Inclusive Care for the Elderly (PACE)	This program is for disabled persons (age 55 years or older) and persons age 65 or older residing in selected counties within the state. Individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Based on income level, some individuals are responsible for a portion of the cost of their care.
Medicare Savings Program (Medicare Costs)	This program is for people who have Medicare and helps with some of the costs. This program pays the Medicare Part B premiums and may also pay Medicare co-payments and deductibles.

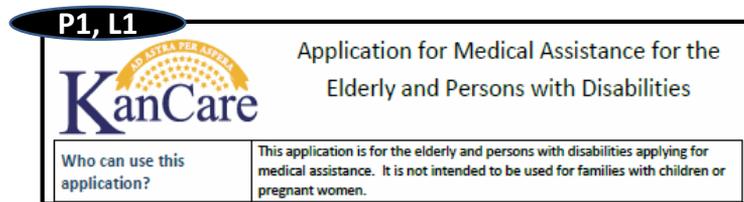
Gives information on:

- Who can use this application?
- How to apply?
- What type of services does KanCare cover?
- What programs can I apply for with this form?

Who Can Use this Application?

This application is for individuals who are:

- Elderly (65 and older)
- Persons with Disabilities (child or adult) - persons determined blind or disabled by Social Security rules (SSDI and/or SSI) or trying to get there (have pending disability case with Social Security)
- Reminder: Persons applying for Nursing Facility, Home and Community Based (HCBS) waiver programs, and PACE program would also use this application.



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Clarification on “trying to get there (PMDT)”:

Someone who has recently applied for disability through the Social Security Administration (SSA), or someone who has been denied disability by SSA, but they are actively appealing that denial.

Clarification on Children under 19:

A child under 19 will use the Families with Children application if applying for regular Medicaid or CHIP. However, if they are applying for the Medically Needy program, Nursing Facility Program, or for an HCBS waiver program, they’ll use the Elderly and Persons with Disabilities application.

Note on Waiver Programs (and Proof of Pending Disability):

Adult consumers (18 + years of age), if not already on SSI/SSDI, must apply for SSI/SSDI if applying for any of the following HCBS Waivers: TBI, PD or I/DD.

Children under 18 do not have to apply for SS-DS, even if applying for a waiver program.

How to Apply?

To apply for medical coverage use any of the following choices:

1. Call the Clearinghouse at 1-800-792-4884 to request an application be mailed to you.
2. [Applications can be downloaded](#) from the KanCare or KDHE websites.
3. [Apply online](#) from the KanCare or KDHE websites.

P1, L2

Apply faster online

GO!

Would you rather apply online?

Apply faster online at www.applyforKanCare.ks.gov

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- You are able to attach additional documents to the online version of the application (ex: proof of income, proof of resources, proof of health insurance, etc.).
- If the applicant decides to apply on-line and does not attach copies of these documents to the online application, they can mail or fax the documentation they need (proof of income, etc.) to the Clearinghouse separately. Please do so as soon as possible.
- Follow up with the Clearinghouse a few days later to make sure they have received both the application and the separately submitted documentation.
- While you have them on the phone, ask if there is any other documentation they need turned in at this time.
- Be on the lookout for a letter requesting more information. Responding in a timely manner will help you to avoid delays.

What type of services does KanCare cover?

P1, L3-4

This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form.

Medical Assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay for...

- Medical
- Hospital Bills
- Doctor's Visits
- Medicine
- Medicare Premiums
- In-Home Assistance Services
- Nursing Home Care
- Institutional Care

Which Medical Assistance Programs can you apply for using this application?

P1, L5-11

On page 3, you will be asked which type of help you want for each member of your household. The definition of each type of coverage is listed below. Please refer to these when answering.

Medically Needy (Spendedown)	This program is for elderly and disabled persons who live in the community. Based on income level, some individuals are responsible for a portion of their medical expenses (spendedown) before coverage begins.
Working Healthy	This program is for disabled or blind persons between the ages of 16 to 64 who are working. Based on income level, some individuals are required to pay a monthly premium.
Home and Community Based Services (HCBS)	This program is for persons who have a medical need for services in the community which can keep them out of an institution. There are currently 7 different HCBS programs, each with a different set of rules. Based on income level, some individuals are responsible for a portion of the cost of their care.
Nursing Home or Other Facility	This category of coverage is for children and adults residing in a nursing home, medical or mental health institution or similar facility for a long term stay. Based on income level, some individuals are responsible for a portion of the cost of their care in the facility.
Program of All-Inclusive Care for the Elderly (PACE)	This program is for disabled persons (age 55 years or older) and persons age 65 or older residing in selected counties within the state. Individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Based on income level, some individuals are responsible for a portion of the cost of their care.
Medicare Savings Program (Medicare Costs)	This program is for people who have Medicare and helps with some of the costs. This program pays the Medicare Part B premiums and may also pay Medicare co-payments and deductibles.

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What types of assistance does this person need? Check all that apply.

C. Tell us about Yourself and the People in your home L16
List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
First Name			
Middle Name			
Last Name			
Maiden Name			
How is this person related to other household members?	Person 1 is my Self - Person 1	Person 2 is my Self - Person 2	Person 3 is my Self - Person 3
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Does this person live at the same address as you?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, list address:			
Has this person lived in a state other than Kansas in the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, when and where?			
Is this person applying for medical assistance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what types of assistance does this person need? Check all that apply. (see page 1 for descriptions of programs)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)
Does this person have a guardian or conservator?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

If yes, complete additional questions on page 14

Is this person applying for medical assistance?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes, what types of assistance does this person need? Check all that apply.</p> <p>(see page 1 for descriptions of programs)</p>	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)

P3, L16

FAQ: If I am on the Waiting List for one of the HCBS Waivers, should I wait or should I go ahead and check the HCBS box now?

If I check it now and there are no open spots in the HCBS program I want, will my application just sit at the Clearinghouse, unprocessed?

Answer: The KDHE Eligibility Team recommends that anyone interested in any of the HCBS programs should apply for KanCare right away, waiting list or not.

If you check the HCBS box before your position on the waiting list is ready, your application will still be worked for any programs the eligibility team can give them, such as Medicare Savings Program (QMB, LMB, ELMB) or a Medically Needy (Spenddown). It is OK to go ahead (and recommended) and check that HCBS box.

Medicare Costs vs. Medicare Costs ONLY

- Checking the **Medicare Costs** box alerts eligibility specialists to check for their ability to enroll in a Medicare Savings Plan.
- Checking the **Medicare Costs ONLY** box asks that Medicaid coverage not be considered, only the Medicare savings program.

Is this person applying for medical assistance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what types of assistance does this person need? Check all that apply. (see page 1 for descriptions of programs)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)

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P3, L16

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If you have someone who *may be eligible for both* Medicare and Medicaid, they can complete a KanCare application (16 pages in length). Be sure to remind them to check the “I’d like help with Medicare Costs” box on page 3 of the application.

This is a screenshot of the KanCare application form, page 3. It features a section titled 'I'd like help with Medicare Costs' with a checkbox. Below this, there are several rows of checkboxes for different types of assistance: Medically Needy, Working Healthy, HCBS, Nursing Home, PACE, Medicare Costs, and Medicare Costs ONLY (no other assistance). The form also includes a section for 'Other Medicaid (Be specific)'.

If you have someone who knows they are *not* eligible for Medicaid, but they need help with their Medicare premiums and co-payments, they can complete a Medicare Savings Program application. (3 pages in length)

This is a screenshot of the Medicare Savings Program application form. It includes a header section with the title 'Application/Determination Medicare Savings Plans'. Below the header, there are several sections: 'This application is only for the following types of assistance:', 'Eligibility Requirements', 'Application Information', and 'Signature'. The form contains various checkboxes and text input fields for personal information and program details.

Page 2

KC1900
1/16

Follow these steps to apply:

- Complete this form to apply. If you need help or have questions, call 1-800-792-4884. Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Sign and date this form. Your application is not complete until it is signed.
- A lot of items we may need from you is on the last page of this form.

Mail your signed application form to:
 KanCare Clearinghouse
 P.O. Box 3599
 Topeka, KS 66601-9738
or Fax it to: 1-844-264-6285

A. Tell us why you are applying
 To help us better meet your needs, tell us why you are applying:

B. Tell us about the Primary Applicant
 The Primary Applicant is the person needing medical assistance.

Your Name: (First, Middle, Last)		Other names used:	
Home Address:		Mailing Address (if different):	
City:	State:	City:	State:
County:	Zip:	County:	Zip:

Check here if you don't have a home address. You still need to give a mailing address.

Home Phone: () — Work Phone: () —

I would like to get information about this application by:

Email: No Yes Email Address: _____

Text: No Yes Cell Phone Number: () —

What language do you speak at home?	What language do you read at home?
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For help completing this application, call toll free: 1-800-792-4884

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A reminder to:

- Answer honestly.
- Sign and date the last page of the application.
- Send in documentation proving what you've claimed.

Follow these steps to apply:

- Complete this form to apply. If you need help or have questions, call 1-800-792-4884. Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Sign and date this form. Your application is not complete until it is signed.
- A list of items we may need from you is on the last page of this form.

Mail your signed application form to:

KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738

or Fax it to: 1-844-264-6285

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P2, L1-3

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Send in proof of what you claim (page 16).

KC1500
1/16

Information You May Have to Provide

When you submit this application form you need to send proof of certain things. Please review this list carefully and send the required proof with your application form. By sending all of the required proof, your application can be processed more quickly.

Proof of Income

If you are reporting that you have a job
We may need copies of your paystubs for the last 30 days, or a statement from your employer with your gross income (before deductions.)

If you are reporting that you are self-employed
You must send your most recent personal and business income tax returns, including all pages and attachments.

If you are reporting that you have other income
We may need a copy of the check or benefit letter that shows the amount of income you get and how often you get the payment.

If you have unpaid medical bills from the past 3 months and would like help
We may need copies of all paystubs or checks your family has received in the past 3 months.

Proof of Resources

If you are reporting that you have a checking account, savings account, stocks/bonds or CDs
You must send a copy of your most recent bank statement.

If you are reporting a Funeral or Burial Plan
You must send a copy of the plan.

If you are reporting a Trust or Annuity
You must send a copy of the trust or annuity.

If you are reporting life insurance
You must send a copy of the life insurance policy.

If you are reporting ANY resources, proof must be sent to us.

Did you remember to:

- Fill everything out?
- Tell us about everyone in your family and household, even if they don't need medical assistance?
- Sign this application on page 15?

Proof of Health Insurance

If you are reporting that someone in the household has other health insurance
We may need a copy of the front and back of your health insurance card. You also must send a bill that shows how much you pay for the insurance.

Remember to sign & date page 15!

K. Signature Page

You must sign and date this form before you send it back. If this form is not signed, it will be returned to you. This will cause a delay in processing your application. Read the information below. Sign and Date.

I understand:

- I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.
- I have the right to have information I have provided kept confidential unless directly related to the administration of Kansas medical assistance programs.
- I have to provide or apply for a Social Security number for anyone who is applying for health benefits and I authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the Social Security Administration, and Internal Revenue Service.
- It is important to provide current income, address, and household composition information, and I am responsible for reporting changes during the application process and while eligible.
- Some or all of the people for whom I am applying may receive similar health coverage under the Medicaid program if eligible.
- 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 have a legal obligation to pay any or all of the medical expenses of those for whom I am applying. I understand that payment for a particular service may be withheld until 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 subscription unit in pursuing those third-party resources.
- If I receive medical assistance after age 64 or while in an institutional arrangement, there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institutions 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 provide false or purposefully misleading information on this application or false information requested by the application, I will be subject to penalties for my actions.
- I have the right to request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household are determined eligible for medical assistance.
- To help Child Support Services (CSS) in establishing and enforcing support orders (if needed) if adults in the household are determined eligible for medical assistance.
- To pay the Working Healthy premium each month if I qualify for that program. The premium may be as little as \$0 or as much as \$205 depending on my income.

I certify:

- That everyone I am requesting health coverage for – and who is determined eligible for such coverage – is a U.S. citizen or a non-U.S. citizen in lawful immigration status. Proof of immigration status may be required. (Exception: persons applying for emergency medical assistance under SCBRA)
- 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 physicians and other medical providers, or managed care organizations for covered medical and other health services furnished to those for whom I am applying and who are eligible.
- Medical providers to release medical information to the Kansas Department of Health and Environment, Division of Health Care Finance (KDHF), the Department for Children and Families (DCF), the Kansas Department for Aging and Disability Services (KDADS), the U.S. Department of Health and Human Services, insurance companies, and other contracted medical providers. I also authorize KDHF, DCF, and KDADS to share medical information for administrative purposes with other agencies and contractors.
- Employers, medical providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances, to release to KDHF, DCF, KDADS, or other benefit programs, any information including financial and other confidential information necessary to establish my eligibility.

My signature on this application signifies that I have read and understand the conditions above. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from this date. A copy of this authorization is as valid as the original.

Signature of Applicant (required) _____ Date _____

Signature of Other Adult Applying _____ Date _____

Signature of First Witness (if "X" is used) _____ Date _____

Signature of Second Witness (if "X" is used) _____ Date _____

Signature of Medical Representative (if applicable) _____ Date _____

For help completing this application, call toll free: 1-800-792-4884

FOR AGENCY USE ONLY:

Would you like to register to vote today?
No _____ Yes _____ Already registered _____

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Page 2, Section A

- If there are services needed for a specific reason, tell us about it in this section.
- It could be as simple as writing in: “I am needing help paying for nursing home expenses.”

A. Tell us why you are applying To help us better meet your needs, tell us why you are applying:	P2, Section A

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Examples of what might go here:

- If you have an individual that is an immigrant, refugee or asylee that fits a “Medicaid-eligible non-citizen” status, note that here, and specify the specific immigrant status along with what documentation you’re submitting with the application.
*See Eligible non-citizens, on slides 72-73 of this lesson.
- If you need “Division of Assets” request that here.
- If you have an urgent medical need, and you’re requesting that your application be expedited, request that here (and attach a letter explaining the details to the front of the application).

Division of Assets



Division of Assets

(Federal Spousal Impoverishment Provisions)

The spousal impoverishment provisions of the Medicaid program changes the Medicaid eligibility requirements for a person who needs long term care in a nursing home or Home and Community-Based Services (HCBS) setting when there is a spouse who remains at home. It protects a portion of the couple's income and resources so the spouse at home is not reduced to poverty. At the same time, these provisions help the spouse needing long-term medical care to qualify for Medicaid benefits, which can help in paying for that care.

Resource Limits:

As of 04/15, the amount of the couple's nonexempt resources which can be protected is the greater of:

- \$23,844 or
- 1/2 of the value of the couple's nonexempt resources owned at the time the husband or wife first entered long term care, not to exceed \$119,220

These \$23,844/\$119,220 allowance limits are subject to change annually due to increases in the federal consumer price index.

Only nonexempt resources are considered. This would include such things as checking and savings accounts, land and/or buildings other than an exempted home. The protected resources must usually be transferred to the spouse in the community and are not considered in determining the eligibility of the person in long term care.

Income Limits:

The amount of the couple's combined income which can be protected is either:

- Up to \$1,912 per month, or
- Up to \$2,981 per month if there are excess shelter expenses

In addition, up to \$664 per month can be protected for each dependent family member who lives with the spouse who remains at home. A dependent family

Last Modified: December 30, 2015

- The spousal impoverishment provisions of the Medicaid program changes the Medicaid eligibility requirements...
- when one spouse needs long term care coverage (LTC Programs: Nursing Home, HCBS and PACE) and the other does not.

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The URL for **The Division of Assets Fact Sheet:**

http://www.kdheks.gov/hcf/Medicaid/download/Division_of_Assets.pdf

Division of Assets



Kansas Medical Assistance

Division of Assets
(Federal Spousal Impoverishment Provisions)

The spousal impoverishment provisions of the Medicaid program changes the Medicaid eligibility requirements for a person who needs long term care in a nursing home or Home and Community-Based Services (HCBS) setting when there is a spouse who remains at home. It protects a portion of the couple's income and resources so the spouse at home is not reduced to poverty. At the same time, these provisions help the spouse needing long-term medical care to qualify for Medicaid benefits, which can help in paying for that care.

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These \$23,844/\$119,220 allowance limits are subject to change annually due to increases in the federal consumer price index.

Only nonexempt resources are considered. This would include such things as checking and savings accounts, land and/or buildings other than an exempted home. The protected resources must usually be transferred to the spouse in the community and are not considered in determining the eligibility of the person in long term care.

Income Limits:

The amount of the couple's combined income which can be protected is either:

- Up to \$1,912 per month, or
- Up to \$2,981 per month if there are excess shelter expenses

In addition, up to \$664 per month can be protected for each dependent family member who lives with the spouse who remains at home. A dependent family member is defined as a child, grandchild, or other dependent family member who is under 18 years of age, is a student, or is otherwise dependent on the spouse who remains at home.

Last Modified: December 30, 2015

- It protects a portion of the couple's income and resources so the spouse at home is not reduced to poverty.
- At the same time, these provisions help the spouse needing long-term medical care to qualify for Medicaid benefits, which can help in paying for that care.

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See additional **FAQs regarding Division of Assets** on the KDADS website: <http://www.kdads.ks.gov/commissions/commission-on-aging/spousal-impoverishment-law>

FAQ: Where can I find the “Division of Assets” form to turn in with my application?

- There is no **Division of Assets form** available to submit before you apply. Once you’ve applied, the Clearinghouse will provide you with the appropriate forms to be completed.
- An applicant may request a Division of Assets on page 2 of the application.
- They may also call the KanCare Clearinghouse: 1-800-792-4884.

A. Tell us why you are applying
To help us better meet your needs, tell us why you are applying:

P2, L4

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LTC Programs for which a Division of Assets (Spousal Impoverishment Provision) would be completed:

1. Nursing Home
2. HCBS
3. PACE

Primary Applicant Contact Information

B. Tell us about the Primary Applicant The Primary Applicant is the person needing medical assistance.			
Your Name: (First, Middle, Last)		Other names used:	
Home Address:		Mailing Address (If different):	
City:	State:	City:	State:
County:	Zip:	County:	Zip:
<input type="checkbox"/> Check here if you don't have a home address. You still need to give a mailing address.			
Home Phone: () -		Work Phone: () -	
I would like to get information about this application by:			
Email: <input type="checkbox"/> No <input type="checkbox"/> Yes	Email Address:		
Text: <input type="checkbox"/> No <input type="checkbox"/> Yes	Cell Phone Number: () -		
What language do you speak at home?		What language do you read at home?	

P2, Section B

What's important to know:

- A correct phone number and correct address are important.
- When assisting a nursing facility resident, the home address entered should be the address of the facility where the individual resides.

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Email and text are not important; at this time KDHE does not use these forms of communication.

What if the applicant has a P.O. Box?

An applicant can use a PO BOX as a mailing address. They have to tell the eligibility team where they physically live (in Kansas); that could be "homeless."

Note to Nursing Homes:

People in Nursing homes must have their residential and their mailing address as the Nursing Home. **If they want their mail to go elsewhere, they have to have a medical representative.**

Using NF as Address on Application - FAQs

- **Question 1:** If someone is applying for Nursing Facility coverage, and they're living in the NF, they are supposed to put their physical and mailing address as the NF's address. Correct? **Yes, that is correct.**
- **Question 2:** What about the address for residents in a nursing home that have a spouse outside the facility? In cases where a spouse is living at home, does the applicant use the home address or the nursing facility address? **The nursing facility address; the spouse will be added as a medical representative and will have his or her own address in the system (med rep will receive all same letter correspondence member/applicant receives).**
- **Question 3:** If we only have a short term resident that will be going home in a few months? What address do we use then? **The nursing facility address.**

Page 3

K1500
1/16

C. Tell us about Yourself and the People in your home
List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
First Name			
Middle Name			
Last Name			
Maiden Name			
How is this person related to other household members?	Self - Person 1	Self - Person 2	Self - Person 3
Person 1 is my:			
Person 2 is my:			
Person 3 is my:			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Does this person live at the same address as you?		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, list address.			
Has this person lived in a state other than Kansas in the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If No, when and where?			
Is this person applying for medical assistance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, what types of assistance does this person need? Check all that apply. <small>(See page 1 for descriptions of programs.)</small>	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)
Does this person have a guardian or conservator?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes, complete additional questions on page 14		

For help completing this application, call toll free 1-800-762-4888

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Tell us about yourself and the people in your home:

- The individual needing medical assistance should be entered as **Person 1** (if they are an adult, 18+ years).
- Their spouse would be entered as **Person 2**. The spouse's information must be entered, even if they do not need medical assistance.
- And anyone else living in the household would be entered as **Person 3** (even if they do not need medical assistance).

P3, Section C		Person 1 Yourself	Person 2	Person 3
First Name				
Middle Name				
Last Name				
Maiden Name				
How is this person related to other household members?	Person 1 is my:	Self – Person 1		
	Person 2 is my:		Self – Person 2	
	Person 3 is my:			Self – Person 3

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You will need to attach another sheet of paper if more than three people reside in the home.

What if individual needing assistance is under 18 years old?

If adult is filling out the application for someone younger than 18, the adult is Person 1 and the child is Person 2, even if the adult does not need medical assistance.

Family members, friends and neighbors helping someone to complete the application:

They will **not** include their information in this section unless they are a member of the household.

P3, Section C

C. Tell us about Yourself and the People in your home

List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
--	-------------------	----------	----------

Mistakes often made on Page 3, Section C:

- Many who assist nursing home residents may think they should enter information about themselves here. **This is incorrect.**
- Adult children holding Durable Power of Attorney (DPOA) often enter their information here. **This is incorrect (unless they are also living in the household of the individual applying for medical assistance).**

P3, Section C		
C. Tell us about Yourself and the People in your home		
List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.		
	Person 1 Yourself	Person 2
		Person 3

Non-household members helping someone with the application:

If the person assisting them is not living with the applicant, they will complete the information on page 14 instead.

P14, Section J

J. Choose Someone to Help You With Your Medical Assistance Case

Primary Applicant - If you are completing this application on behalf of someone for whom you are the Guardian, Conservator, Financial Power of Attorney or Social Security Payee, please complete the information below and submit proof.

First and Last Name			
Address Line 1			
Address Line 2			
City	State	Zip Code	
Phone Number	Email Address		

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If you claim that you are guardian, conservator, have DPOA, or payee, be sure to submit proof with the application.

Report Everyone in the Household

- If they are not applying for Medicaid coverage - **You still need to include them.**
- If they are not applying for insurance, the information you give on them may be very basic.

P3, L1-14

C. Tell us about Yourself and the People in your home
List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
--	-------------------	----------	----------

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Each medical program has different income/asset rules.

On the application, list each person who is living in your home. The eligibility worker will decide who must be included in your household to determine if you're eligible for a specific program.

Different income/asset rules apply to different programs. Sometimes:

- For adults: The income/assets of the person needing coverage **and** their spouse is used.
- For adults: The income/assets of only the person needing LTC coverage is being counted, after a Division of Assets has been completed.
- For children: The income of the children **and** the parents who live with them is counted.
- For children: The income of only the child is counted.
- Some programs count assets/resources, and some do not.

List Each Member of Your Household

For Example:

P3, L1-7

C. Tell us about Yourself and the People in your home
 List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
First Name	Rickey	Lucy	Howard
Middle Name			
Last Name			
Maiden Name			
How is this person related to other household members?	Person 1 is my: <i>Self - Person 1</i>	husband	dad
	Person 2 is my: wife	<i>Self - Person 2</i>	mom
	Person 3 is my: son	son	<i>Self - Person 3</i>

Who Needs Medical Assistance & Which Type

- Once each member of your household has been listed...
- Make sure you've distinguished whether or not they are to be included in the request for Medicaid coverage
- By checking **yes** or **no** boxes

P3, Line 15

C. Tell us about Yourself and the People in your home

List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if you are not applying for them. If you have more than 3 people in your home, please attach another sheet of paper and send it with your application.

	Person 1 Yourself	Person 2	Person 3
Is this person applying for medical assistance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

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Who Needs Medical Assistance & Which Type

<p>Is this person applying for medical assistance?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>If yes, what types of assistance does this person need? Check all that apply.</p> <p>(see page 1 for descriptions of programs)</p> 	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input checked="" type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (no other assistance)

P3, L15-16

- If you have checked **Yes** (this person is applying for medical assistance)
- Be sure to indicate what types of assistance this person needs.
- Check all that apply.

Who Needs Medical Assistance & Which Type

<p>Is this person applying for medical assistance?</p> <p>If yes, what types of assistance does this person need? Check all that apply.</p> <p>(see page 1 for descriptions of programs)</p> 	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Medically Needed</p> <p><input type="checkbox"/> Working Healthy</p> <p><input checked="" type="checkbox"/> HCBS</p> <p><input checked="" type="checkbox"/> Nursing Home</p> <p><input type="checkbox"/> PACE</p> <p><input type="checkbox"/> Medicare Costs</p> <p><input type="checkbox"/> Medicare Costs ONLY (no other assistance)</p>
--	--

P3, L15-16

It is important to check the right types of assistance to speed up application processing time.

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Important Note to Nursing Homes:

- Does your facility have both “skilled nursing” and “assisted living” sections? If so, it is very important to know which section the resident is living in. Leaving the correct box blank or marking the wrong “type of assistance” will add to the application processing time.
- If the resident applying for medical assistance is residing in the “skilled nursing” section of your nursing home, you MUST check “nursing home.”
- If the resident applying for medical assistance is residing in the “assisted living” section of your nursing home, you MUST check “HCBS.”
- If you have a family that is helping your resident apply for Medicaid, make sure they know which program to apply for (which box to check). Many families are not familiar with the difference between “assisted living” and “nursing home.”

Another Note to Nursing Homes:

What items must be completed and submitted in order to fully process the KanCare application?

1. KanCare Application for the Elderly & Persons with Disabilities (KC-1500)
2. 2126 form must be completed and submitted (by the facility, NOT by the consumer) for all admissions and discharges
3. CARE Assessment (indicates the resident meets the level of care to be in the facility) is completed by KDADS/ADRC.

Not sure which program to apply for?

 Application for Medical Assistance for the Elderly and Persons with Disabilities	
Who can use this application?	This application is for the elderly and persons with disabilities applying for medical assistance. It is not intended to be used for families with children or pregnant women.
Apply faster online	GO! Would you rather apply online? Apply faster online at www.applyforKanCare.ks.gov
This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form.	
Medical Assistance	Medical Assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay for medical and hospital bills, doctor's visits, medicine, Medicare premiums, in home assistance services, nursing home and institutional care.
On page 3 of this application you will be asked to indicate the type of help you want for each member of your household. The definition of each type of coverage is listed below. Please refer to these when answering.	
Medically Needy (Spendedown)	This program is for elderly and disabled persons who live in the community. Based on income level, some individuals are responsible for a portion of their medical expenses (spendedown) before coverage begins.
Working Healthy	This program is for disabled or blind persons between the ages of 16 to 64 who are working. Based on income level, some individuals are required to pay a monthly premium.
Home and Community Based Services (HCBS)	This program is for persons who have a medical need for services in the community which can keep them out of an institution. There are currently 7 different HCBS programs, each with a different set of rules. Based on income level, some individuals are responsible for a portion of the cost of their care.
Nursing Home or Other Facility	This category of coverage is for children and adults residing in a nursing home, medical or mental health institution or similar facility for a long term stay. Based on income level, some individuals are responsible for a portion of the cost of their care in the facility.
Program of All-Inclusive Care for the Elderly (PACE)	This program is for disabled persons (age 55 years or older) and persons age 65 or older residing in selected counties within the state. Individuals receive long term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility. Based on income level, some individuals are responsible for a portion of the cost of their care.
Medicare Savings Program (Medicare Costs)	This program is for people who have Medicare and helps with some of the costs. This program pays the Medicare Part B premiums and may also pay Medicare co-payments and deductibles.

- If you're not sure...
- Refer back to page 1 of the application.
- Definitions of the different types of assistance available.

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Or see the *Over view of Programs for Elderly and People with Disabilities Fact Sheet*, URL: http://www.kancare.ks.gov/docs/default-source/Consumers/benefits-and-services/fact-sheets/overview-of-ed-programs_04-18.pdf?sfvrsn=4

Bottom of Page 3

- **Guardian** - a person who is entrusted by law with the care of the person or property, or both, of another, as a minor or someone legally incapable of managing his or her own affairs.
- **Conservator** - a legal guardian; a custodian.
- If **Yes**, complete additional questions of page 14.
- If **Yes**, it should be your signature on the application on page 15.

Does this person have a guardian or conservator?

No Yes

3/3/2020

P3, L7

Page 4

HC2000
1/16

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and last name			
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-775-2333 or visit www.hawaiihealthcare.gov.			
Social Security #			
U.S. citizen? <i>(Required to answer if applying for medical assistance)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
State and Country of birth			
Race (optional) <i>Check all that apply</i>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Other <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Hawaiian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Other <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Hawaiian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Other <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Hawaiian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other
Ethnicity (optional) <i>If Hispanic/Latino ethnicity, check all that apply.</i>	<input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other	<input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other	<input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other
Has this person delivered a baby in the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does this person need help paying medical bills from the last 3 months (including Medicare premiums)? <i>If yes, please see additional questions on page 5.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Which of the following best describes this person's current living situation?	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility or other institution <input type="checkbox"/> Other	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility or other institution <input type="checkbox"/> Other	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility or other institution <input type="checkbox"/> Other

For help completing this application, call toll free 1-800-762-4854

Section C. Continues onto Page 4

- Applicants are asked to continue answering questions about themselves and persons in their household.
- It is important to enter the applicant’s social security number **and** the social security number for anyone living in the household (even if not applying for medical assistance) to avoid processing delays.

P4, L1-4			
	Person 1 Yourself	Person 2	Person 3
First and Last Name			
<p>We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov</p>			
Social Security #			

Note: The Eligibility Team needs Social Security Numbers (SSNs) for everyone applying for medical assistance. **People on the application who are not applying for medical assistance for themselves may choose not to give their SSN.**

But if there is income to allocate, for example, from a spouse who lives in a nursing home to a spouse who lives in the community (or for another long term care program), having the SSNs for both can speed up the application process.

The Eligibility Team uses SSNs to check income and other information to find out who qualifies for medical assistance.

Note: If someone does not have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov .

U.S. Citizen?

U.S. citizen? (required to answer if applying for medical assistance)	<input type="checkbox"/> No <input type="checkbox"/> Yes
State and Country of birth	

P4, L5

Immigration Status: Please provide immigration status for everyone applying who is NOT a U.S. citizen. (Please note: Applying for KanCare medical assistance does not affect your immigration status.)			
Name (First, Middle, Last)	Document Type	Immigration number	Immigration status

P5, L25-26

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To be potentially eligible for KanCare, an individual must be:

1. Kansas resident **and**
2. US Citizen or a eligible non-citizen

Eligible Non-Citizen

To be considered eligible for any of the KanCare medical assistance programs, non-U.S. citizens must:

- Hold legal residency in the U.S. for 5 years or more or
- Hold a certain immigration status and be able to submit certain documentation.

Immigration Status: Please provide immigration status for everyone applying who is NOT a U.S. citizen.

(Please note: Applying for KanCare medical assistance does not affect your immigration status.)

Name (First, Middle, Last)	Document Type	Immigration number	Immigration status

P5, L25-26

Which immigrant statuses do not require 5 years legal residency?

Those individuals with a status listed below (Eligible Non-Citizens, KEESM Code: 2140):

1. Refugees admitted under 207 of the Immigration and Nationality Act (INA)
2. Asylees granted asylum under 208 of the INA
3. Aliens whose deportation has been withheld under Section 243 (h) of the INA
4. Cuban or Haitian entrants as defined in section 501 of the Refugee Education Assistance Act of 1980;
5. Non-citizens who are certified victims of severe forms of trafficking, and some family members, who are admitted to the U.S. as refugees under section 207 of the INA.

For the most updated and additional information, see the Medical KEESM Manual:

<https://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy/manuals>
(Search KEESM with code 2140, then look for code 2142.1 Eligible Non-Citizens, and 2142.2 Non-Citizens Who Qualify After 5 years).

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How to find possible Eligible Non-Citizen statuses:

- For KEES Manual: <https://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy>
- Type in the word(s) to search for: 2142.1 (Eligible Non-Citizens)

See the KanCare Ombudsman General Information Fact Sheet on *Medical Assistance for Refugees, Asylees and Immigrants*, URL:

[http://www.kancare.ks.gov/docs/default-source/KanCare-Ombudsman/resources/general-fact-sheets-\(english\)/refugee---immigration-fact-sheet.pdf?sfvrsn=4](http://www.kancare.ks.gov/docs/default-source/KanCare-Ombudsman/resources/general-fact-sheets-(english)/refugee---immigration-fact-sheet.pdf?sfvrsn=4)

What documentation proves Medicaid-eligible immigration status?

- **The KDHE Eligibility Team must have proof that the applicant(s) have applied for Social Security (as all Medicaid recipients must have a Social Security Number to receive Medicaid).** Once the applicant has received a Social Security Number, they are required to update KanCare with that information.
- **Additional documentation** such as I-94, Travel Documents, Employment Authorization Card (EAD) and Green Card may also be required in these cases.
- See the [Office of Refugee Resettlement \(ORR\) State Letter](#) for specifics on what documentation is required:
<www.acf.hhs.gov/sites/default/files/orr/orr_state_letter_508_0.pdf>
- KanCare Ombudsman office recommends that you send all of your required documentation **with** the KanCare application, to help avoid delays.

We also recommend that you attach a letter or note clearly on the front of the application explaining that the applicant is a potentially **eligible non-citizen** and note what citizenship/alien status documentation you've enclosed with the application.

Also in this section, Page 4...

Place of Birth, Race & Ethnicity (optional)

P4, L6-8

State and Country of birth						
Race (optional) Check all that apply	<input type="checkbox"/> White <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> White <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> White <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a	<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other	<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a	<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other	<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a	<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other

Also in this section, Page 4...

New Baby?

Has this person delivered a baby in the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes P4, L9
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Emergency Care in the Last 3 Months?

Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	<input type="checkbox"/> No <input type="checkbox"/> Yes P4, L10
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What about non-citizens that are *not* eligible for KanCare?

- SOBRA (Sixth Omnibus Budget Reconciliation Act) is a fee-for-service (state pays the provider directly, no MCO) plan for persons who do not meet citizenship/immigration requirements.
- Persons must still meet income and asset rules to qualify.

Covers only:

- Life- threatening emergency care costs (SOBRA Emergency) and
- Birth/delivery services (SOBRA Labor and Delivery)

What are the SOBRA Income and Asset Requirements?

Depends on the path. SOBRA is not a standalone program, but one that is attached to other categories.

For example:

- If a woman is applying for **SOBRA – Birth and Delivery**, the eligibility team would attach it to the KanCare **Pregnant Woman Program**.
- And the income and asset/resource limits would match that of the Pregnant Woman Program. So there'd be no resource/asset limits, and the income limits would be the same you see on the KanCare Pregnant Woman Fact Sheet.
- However, even if she were over the income limit for the Pregnant Women program, she might still qualify for the **KanCare Medically Needy Program** (which would mean she'd be eligible, but have a spenddown).

Populations that may qualify for Medically Needy: Age 65 and over, Children under 19, Persons with Disabilities, Pregnant women.

Asset/Resource Limits for Medically Needy: For pregnant women and children, there is no resource test. For seniors and people with disabilities, there is a resource limit of \$2000 for singles and \$3000 for couples.

The Long Term Care programs, HCBS, PACE and Nursing Home are the only programs that SOBRA could not be attached to.

General explanation of SOBRA income and asset limits

For Families with Children, Pregnant Women and Children programs:

- No asset/resource limits (because there are no asset/resource limits on those KanCare programs).
- Then their income limit would be the same as the program they'd match with or be attached to (Parent/Caregiver, Child or Pregnancy Program).
- If their income was over the limit for one of the programs just mentioned, they may still qualify for SOBRA with a spenddown (because SOBRA would then be attached to the Medically Needy Program).

General explanation of SOBRA income and asset limits

For people over 65 or those with disabilities (determined by Social Security rules):

- \$2,000 asset/resource limits (for single individuals) because these are the asset/resource limits on those KanCare programs.
- Then they may or may not have a spenddown, depending up on their income.
- SOBRA **cannot** be attached to any of the Long Term Care Programs (Examples: HCBS, PACE, or Nursing Facility), nor to any non-Medicaid programs (Examples: MediKan, Medicare Savings Programs)

Populations that may qualify for Medically Needy: Age 65 and over, Children under 19, Persons with Disabilities, Pregnant women.

Asset/Resource Limits for Medically Needy: For pregnant women and children, there is no resource test. For seniors and people with disabilities, there is a resource limit of \$2000 for singles and \$3000 for couples.

How do I apply for SOBRA?

- If applying for **SOBRA – Labor and Delivery**, apply **after** your baby has been born. It's not something you can apply for ahead of time.
- The individual has to apply for coverage using the **KanCare application**, but again, only after the incident.
- You could write **SOBRA** on the application (at the top, in big letters) but the Clearinghouse should be able to figure out that it's a SOBRA applicant without the SOBRA heads up.
- Once KDHE's eligibility team starts the SOBRA process they will mail the hospital a SOBRA form to fill out.
- KDHE only gives the hospital the SOBRA form once they've determine the person is financially eligible.

FAQ: How long after the life-threatening emergency or birth/delivery can someone apply for SOBRA? I realize they'll usually sign up at a hospital when this emergency or birth/delivery occurs. But if they did not, and someone at a clinic, for example, helps them to sign up later...is it 3 months like many other programs? Yes

Answer: Yes, 3 months. They must complete an application to be considered for the program.

Need Help Paying Medical Bills from the Last 3 Months?

- Mark this question **yes** if the applicant needs help paying medical bills that occurred 3 months prior to the month of application.
- Not **all** KanCare programs are retroactive and have the ability to pay for previous medical bills, but some programs do.
- The applicant must mark this question **yes** to allow KDHE to review their eligibility for 3 months prior to the month of application.

Does this person need help paying medical bills from the last 3 months (including Medicare premiums)?	<p style="text-align: right;">P4, L11</p> <p style="text-align: center;"><input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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This includes Medicare premiums!

Note to Nursing Homes:

- It is important to mark this question **yes** if the applicant has been a resident in your facility months prior to completion and submission of this application.
- For example, if the resident was admitted into the facility in on January 10th but the application was not submitted until February 9th, they must mark this question **yes** to allow KDHE to review the applicant's eligibility for January.

Did you request help with medical bills in the past 3 months?

- If so, there are additional questions to answer on page 5.
- Applicant may be eligible for same or different programs during that time.

Help with medical bills in the past 3 months	
Because you have requested help paying medical bills in the past 3 months	
Have there been any changes in the household during the last 3 months? (People moving in or out)	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the household changes:	
Have there been any changes in the household income during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the income changes:	
Have there been any changes in the household assets during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the asset changes:	

P5, L18-24

Asking about changes in:

- Income
- Assets/resources
- Who's living in the household

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See notes on each of these questions in the **Page 5** section of this guide.

Current Living Situation?

P4, L12

Which of the following best describes this person's current living situation?

- Own home
- Renting
- Live with someone else
- Assisted Living
- Hospital
- Nursing Facility or other institution
- Other

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Persons 1, 2, and 3 (continued)
Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Is this person living outside of the home?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, why is this person living outside of the home?			
Date expected to return	/ /	/ /	/ /
If in a hospital, nursing facility or other institution, what is the name of the facility?			
Date Admitted	/ /	/ /	/ /
Date of Discharge	/ /	/ /	/ /
Has this person ever been in a hospital or nursing facility for more than 30 days in a row?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when? (MM/DD/YY through MM/DD/YY)			
Has this person served in the military?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this person the spouse or widow of someone who served in the military?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
What is this person's VA file number?			
Does this person pay for medical expenses?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
How much is the expense?	\$	\$	\$
How often?			
Describe the expense:			
Additional information about the People in your Household			
Help with medical bills in the past 3 months			
Because you have requested help paying medical bills in the past 3 months, please answer these questions.			
Have there been any changes in the household during the last 3 months? (Please include moving in or out)			
	<input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, tell us about the household changes:			
Have there been any changes in the household income during the last 3 months?			
	<input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, tell us about the income changes:			
Have there been any changes in the household assets during the last 3 months?			
	<input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, tell us about the asset changes:			
Immigration Status: Please provide immigration status for everyone applying who is NOT a U.S. citizen. (Please note - Applying for KaCare medical assistance does not affect your immigration status.)			
Name (First, Middle, Last)	Document Type	Immigration number	Immigration status

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Questions about Current and Previous Living Arrangements

- Is this person living outside the home? Answer **yes** or **no**. If **yes**, explain why they are living there.
- If the applicant is residing in a **nursing home**, please answer this question **yes**.

Is this person living outside of the home?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, why is this person living outside of the home?	

P5, L3-4

Date Expected to Return Home?

- If the stay in a facility is temporary, please indicate the date of potential return to home.
- If the stay in a facility is permanent, please indicate permanent stay.

Date expected to return	/ /
-------------------------	-----

P5, L5

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Facility examples (away from home):

<input type="checkbox"/>	Assisted Living
<input type="checkbox"/>	Hospital
<input type="checkbox"/>	Nursing Facility or other institution
<input type="checkbox"/>	Other

Name of the Facility?

- It is very important to list the name.
- If this is a **swing bed facility** please list the hospital name and indicate swing bed facility afterward.

If in a hospital, nursing facility or other institution, what is the name of the facility?	P5, L6
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Swing bed facility - an alternative to prolonged acute hospitalization or short term nursing facility placement for post-acute extended care.

The **swing bed** program provides **skilled nursing care** and **rehabilitation services**.

If not sure, ask the facility what the facility if they were considered a swing bed facility during any time of the individuals time with them.

Date Admitted & Discharged

It is important to enter the date of admission and/or discharge.

Date Admitted	/ /
Date of Discharge	/ /

P5, L7-8

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Note to Nursing Homes:

It is also important for the facility to submit a complete **MS-2126 form** to verify the dates, to determine eligibility and payment approval.

*The consumer will not know what this is; it must be submitted with the application by the long term care facility.

Ever been in a nursing facility for more than 30 days in a row?

- Please list the **admission through discharge dates** in **month/day/year format** when answering this question.
- This question is specific to an applicant who has a spouse, and the applicant is requesting Nursing Home, PACE or HCBS coverage.

Has this person ever been in a hospital or nursing facility for more than 30 days in a row?	<p style="text-align: right;">P5, L9-10</p> <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when? (MM/DD/YY through MM/DD/YY)	

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- KDHE needs to know the applicant's first 30 days stay in a hospital or nursing home.
- This will determine the month and year KDHE's Eligibility Team requests resources to determine how much a spouse can protect of the couple's resources.

Ever Served in the Military?

- If the applicant has ever served in the military, there is the potential of cash benefits from the Veteran’s Administration (VA).
- It is a requirement if you are a veteran, or spouse or current widow of a veteran, (1) to apply for cash benefits from the VA, or (2) submit a letter saying that they are not eligible for cash benefits.
- To apply or for help in getting a letter saying you are not eligible, you can contact the VA Benefits Assistance Service at 1-800-827-1000 or their local [KS Commission on Veterans Affairs](https://kcva.ks.gov/veteran-services/office-locations) office.
- Local office locations: <https://kcva.ks.gov/veteran-services/office-locations>

Has this person served in the military?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this person the spouse or widow of someone who served in the military?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3 What is this person’s VA file number?	P5, L 11-13

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If the applicant is a veteran, or spouse or current widow of a veteran KDHE Eligibility Team must have:

- Verification that the applicant has applied for VA benefits, or
- A letter saying that they are not eligible for cash benefits

Who can help me get this documentation?

- The local *KS Commission on Veterans’ Affairs* offices across Kansas can help people determine if they are eligible to apply, and if not, can write a letter saying that they are not.

KS Commission on Veterans’ Affairs local office locations:

<https://kcva.ks.gov/veteran-services/office-locations>

What type of documentation will the KS Commission on Veterans’ Affairs need to help me find out whether or not I am eligible for VA benefits? You’ll need the veteran’s “Discharge Papers.” For the Korean War or after, it will most likely be the DD214 (Discharge Papers). If you cannot find the discharge papers, the KS Commission on Veterans’ Affairs can help you get those papers. However, you will need to know “when the veteran served.”

Does this person pay out-of-pocket for medical expenses?

- You can enter the applicant’s private or Medicare supplemental insurance premiums here.
- If the applicant has ongoing medical expenses that they pay out of pocket for, you can list this here.

Does this person pay for medical expenses?	<input type="checkbox"/> No <input type="checkbox"/> Yes
How much is the expense?	\$
How often?	
Describe the expense:	

P5, L14-17

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Members may be able to reduce the amount they owe on their Client Obligation (or on their Spenddown) by submitting receipts for medical costs **not** covered by Medicaid or other insurance.

Examples of Allowed Expenses:

- Health Insurance Premiums
- Medicare Premiums
- Medically necessary expenses that Medicaid, Medicare and other health insurance does not cover (for members’ non-covered medical expenses)



Did you request help with medical bills in the past 3 months (3 months prior to month of application)?

If so, there are additional questions to answer on page 5.

Help with medical bills in the past 3 months	
Because you have requested help paying medical bills in the past 3 months,	
Have there been any changes in the household during the last 3 months? (People moving in or out)	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the household changes:	
Have there been any changes in the household income during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the income changes:	
Have there been any changes in the household assets during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the asset changes:	

Asking about changes in:

1. Household
2. Income
3. Assets/resources

P5, L18-24

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Changes in Household (3 months prior to application month)?

- It is important to document if the applicant was in **another living arrangement** during the **3 months prior to the application month**.
- Where they in another facility, hospital, assisted living, or in their own home?
- KDHE may determine eligibility for a different medical program in the prior 3 months based on their living arrangement.

Help with medical bills in the past 3 months		P5, L18-24
Because you have requested help paying medical bills in the past 3 months		
Have there been any changes in the household during the last 3 months? (People moving in or out)	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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Changes in Income (3 months prior to application month)?

- In some cases, applicants have worked in prior months, but are now unable to work and are in need of medical assistance.
- It is important to list any wages and provide copies of pay stubs for each of the prior medical months.

Help with medical bills in the past 3 months	
Because you have requested help paying medical bills in the past 3 months	
Have there been any changes in the household income during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the income changes:	

P5, L18-24

Changes in Assets (3 months prior to application month)

- **For example:** Did the applicant close a savings account and use the funds to set up a funeral arrangement?
- If so, KDHE would need verification that (1) the savings account had been closed and (2) a copy of the funeral arrangements.

Help with medical bills in the past 3 months	
Because you have requested help paying medical bills in the past 3 months	
Have there been any changes in the household assets during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the asset changes:	

P5, L18-24

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Page 6

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Federal Income Tax Information
We have some questions about how you plan to file your taxes. Answer these questions based on your current situation.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Based on your current situation, does this person plan to file a federal income tax return? <i>If yes, please answer questions 1 - 3. If no, please skip to question 4.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
1. Will this person file jointly with a spouse? <i>If yes, name of spouse</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Does this person have any dependents on their tax return? <i>If yes, list name(s) of dependents</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Is this person claimed as a dependent on someone else's tax return? <i>If yes, list the name of the tax filer</i> <i>How is the person related to the tax filer?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
D. Tell Us if You Are Disabled We need to know if any persons in your household have a disability. Note: Personal Health information disclosed here will only be used to determine your disability status and will not be shared with others.			
	Person 1 Yourself	Person 2	Person 3
Does this person have a disability that will last at least 12 months or result in death?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has this person ever applied for Social Security benefits? <i>If yes, answer the questions below.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the application denied? <i>If yes, when?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the denial under appeal? <i>If yes, what is the status?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has the existing condition become worse since the Social Security denial? <i>If yes, explain</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does this person have a new disability or condition that Social Security did not look at? <i>If yes, briefly describe the disability.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is an attorney or someone else helping this person with the Social Security application for disability benefits? <i>If yes, list name of the person and organization.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number of Person or Organization			

For help completing this application, call toll free 1-800-780-4888

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Federal Income Tax Information

Federal Income Tax Information	
We have some questions about how you plan to file your taxes. Answer	
	Person 1 Yourself ↓
First and Last Name	
Based on your current situation, does this person plan to file a federal income tax return?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please a</i>
1. Will this person file jointly with a spouse?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, name of spouse	
2. Does this person have any dependents on their tax return?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list name(s) of dependents	
3. Is this person claimed as a dependent on someone else's tax return?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list the name of the tax filer	
How is this person related to the tax filer?	

P6, L1-11

This is aimed at how the applicant will file their taxes the following April (not how they have previously filed).

Please answer the tax information questions for the:

1. Primary applicant and any
2. Dependents (even if they are not applying for medical coverage).

Tell Us If You Are Disabled

This section asks:

- If anyone in the household has a documented disability, lasting more than 12 months or that will result in death
- About Social Security Benefits (SSI or SSDI), application for disability benefits or previous denials and appeal dates
- Exacerbation of current disabilities (since last filing)
- Presence of new disabilities (since last filing)

P6, Section D

D. Tell Us if You Are Disabled

We need to know if any persons in your household have a disability. Note: Personal Health Information disclosed here will only be used to determine your disability status and will not be shared with others.

	Person 1 Yourself	Person 2	Person 3

Note on Social Security Disability Determination:

If not already on SSI/SSDI, the consumer must apply for SSI/SSDI if 19 years of age or older and applying for one of the following HCBS Waivers: BI, PD and IDD.

Prior to the 19th birthday they don't need SS-DS determination when seeking HCBS services.

Already have a disability determination from Social Security? (SSI or SSDI)

D. Tell Us if You Are Disabled	
We need to know if any persons in your household have a disability. used to determine your disability status and will not be shared with	
	Person 1 Yourself
Does this person have a disability that will last at least 12 months or result in death?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Has this person ever applied for Social Security Benefits?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Was the application denied?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when?	N/A
Is the denial under appeal?	N/A <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what is the status?	N/A
Has the existing condition become worse since the Social Security denial?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, explain	N/A
Does this person have a new disability or condition that Social Security did not look at?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, briefly describe the disability.	N/A
Is an attorney or someone else helping this person with the Social Security application for disability benefits?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list name of the person and organization	N/A
Phone Number of Person or Organization	N/A



If the individual has already been **determined disabled by the Social Security Administration**, they would answer lines 14-16.

If any of the following questions do not apply to you, put N/A (non-applicable)...Don't leave anything blank!

Not Determined Disabled Yet?

P6, L14-26

D. Tell Us if You Are Disabled		
We need to know if any persons in your household have a disability. Note: Personal Health Information is used to determine your disability status and will not be shared with others.		
	Person 1 Yourself	Person 2
Does this person have a disability that will last at least 12 months or result in death?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has this person ever applied for Social Security Benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the application denied?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when?		
Is the denial under appeal?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what is the status?		
Has the existing condition become worse since the Social Security denial?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, explain		
Does this person have a new disability or condition that Social Security did not look at?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, briefly describe the disability.		
Is an attorney or someone else helping this person with the Social Security application for disability benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list name of the person and organization		
Phone Number of Person or Organization		

- Each question in Section D will need to be answered if the individual is under the age of 65 and has **not yet been determined disabled by the Social Security Administration.**
- If a lawyer is involved with the disability case, list them.

Note on *Pending Disability Cases* with Social Security Administration (SSA):

If the disability has not yet been determined by SSA, **applicant must submit documentation with the application** that proves they are applying for (or appealing a denial of) disability benefits through the Social Security Administration.

What verification documentation is needed to prove a *pending disability case* with the SSA?

1. an appointment letter or
2. (copy of the appeal with SSA for recently denied disability determination or
3. something from your most recent mail from the SSA that shows you have a pending disability case.

Page 7- RESOURCES

E. Tell us about your Resources
We need to know about your resources to decide if you can get benefits. If you need more room, attach additional pages.

1. Answer the questions below. Mark No or Yes on each item. If yes, provide details about the resource.

Type of Resource	Name(s) on Resource	Amount or Value	Where is Resource held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Nursing Facility Account	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other	<input type="checkbox"/> No <input type="checkbox"/> Yes			

2. Does anyone in your household have a vehicle? No Yes. If yes, complete the following.

	VEHICLE #1	VEHICLE #2	VEHICLE #3
Year			
Make			
Model			
Owner			
Estimated Value	\$	\$	\$
Balance Owed	\$	\$	\$
Registered in Kansas?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
How do you use the vehicle?			

3. Does anyone in your household have life insurance? No Yes. If yes, complete the following. Include copies of all policies.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
			\$	\$
			\$	\$
			\$	\$

- Be honest and complete. Put everything in here, and let the eligibility team sort it out.
- Not everything you put in this section will be held against you.
- Deductions exist, so make sure you report all money in each specific category.
- Anything you put here will need to be backed up with a statement from the bank or applicable governing body.

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Assets:

Most plans have asset limits. The state may not count some assets.

The state does not count:

- the home where you live (or the land that it sits on)
- one car
- some burial plans
- furniture and household items

The state DOES count other assets:

- bank accounts
- stocks and bonds
- most life insurance policies
- Etc.

The Eligibility Team needs to know about your resources, to determine if you qualify for benefits.

If you answer **yes** to any of these items, you must provide details about the resource.

P7, Lines 1a-1k

Type of Resource		Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Nursing Facility Accounts	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				

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- If you have more than 1 of any of these items, you may need more room to write the required details.
- If you need more room, attach additional pages.

Checking & Savings Accounts

Type of Resource		Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Nursing Facility Accounts	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				

P7, Lines 1b-1c

Checking Account:

- KDHE needs copies of your checking account (s) statement (s) with a full month of activity.
- Provide statements for each month you are requesting coverage.
- If you have more than one checking account, please use the extra lines in this section (“Other_____”) or add another page.

Savings Account:

- Provide statements for each month you are requesting coverage.
- If you have more than one savings account, please use the extra lines in this section (“Other_____”) or add another page.

Certificate of Deposits (CODs) & Retirement Plans

Type of Resource		Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Nursing Facility Accounts	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				

P7, Lines 1d-1e

Certificate of Deposit:

- These are the same as a savings account.
- Provide statements for each month you are requesting coverage.

Retirement Plan:

- This could be an IRA, 401K or other account or funds set up for retirement.
- KDHE requires a statement which reflects the “owner” and the “balance.”

Nursing Facility Accounts and Stocks & Bonds

Type of Resource		Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Nursing Facility Accounts	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				

P7, Lines 1f-1g

Nursing Facility Account(s):

- ***Resident Trust Fund OR Resident Care Home Account.***
- These are the same as a checking account.
- Provide statement (s) with a full month of activity.
- Provide statements for each month you are requesting coverage.

Stocks:

It is important to indicate the “type of stock” AND a statement showing the current value of that stock.

Bonds:

Please provide a copy of your bond (s).

Funeral Arrangements & Burial Plans

Type of Resource	Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Nursing Facility Accounts	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes			

P7, Lines 1h-1i

Make sure you have the following documentation.

Funeral or Burial Plans:

- It is a requirement to verify if a funeral arrangement will be considered an resource to an applicant.
- Please provide a copy of the funeral arrangements.

The copy of these funeral arrangements need to contain:

1. An itemized statement of goods and services,
2. A statement signed indicating that the arrangements are *irrevocable*, and
3. How the arrangements were funded

Burial Plots:

Just indicate if they have one.

Regarding the cap on “exempt funeral arrangements”

- There is no limit to the amount of merchandise or the actual burial space/plot included in an irrevocable funeral plan. Items that would be considered burial space items or merchandise are the casket, urn, outer burial container, headstone/monument, engraving, opening/closing of the grave, interment, etc.
- **There is a limit of \$7,000 for funeral services included in an irrevocable funeral plan. Any services in excess of \$7,000 would be considered a countable resource. Services include the funeral/memorial service, viewing/visitation, transportation, obituary notices, services of the funeral director and staff, honorariums, flowers, etc. This information may be found in the Medical KEESM section 5430(10).**

Does anyone in the household have a vehicle?

2. Does anyone in your household have a vehicle? No Yes If yes, complete the following.

	Vehicle #1	Vehicle #2	Vehicle #3
Year			
Make			
Model			
Owner			
Estimated Value	\$	\$	\$
Balance Owed	\$	\$	\$
Registered in Kansas?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
How do you use the vehicle?			

P7, Lines 2a-2h

Put all vehicle info down - anyone in the house owning a vehicle needs to be included.

The state does not count the following as assets:

- the home where you live (and the land it sits on)
- **one car** → your newest, most expensive vehicle (**note:** if your second and third cars for example are 7 years old or older, may count the value as \$100). Note: Depending on the car, old and high value classics for example, may be assessed differently.
- some burial plans
- furniture and household items

Life Insurance

- It is very common for most applicants to have a life insurance policy.
- The state counts most life insurance policies as assets.
- Not sending in your verification of life insurance policies with your application will increase the application processing time.

3. Does anyone in your household have life insurance? No Yes If yes, complete the following.
Include copies of all policies.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
			\$	\$

P7, Lines 3a-3c

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To verify a policy, we ask the applicant to request a letter from the insurance company, which will contain:

1. the policy number
2. policy owner
3. type of policy (whole life or term)
4. face value,
5. cash value and
6. any loans which have been taken out against the policy

Note: Term life insurance isn't usually a problem. It's the "cash value" of a Whole life policies that will count as a resource.

Page 8 -Resources Continued...

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4. Does anyone in your household own a home? No Yes If yes, complete the following:

Owners	Address	
Date Purchased	/ /	Value \$ Amount Owed \$
Who lives in the home?		
If the owner does not live there, explain why?		
If the owner does not live there, does the owner intend to return home?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, when?		

5. Does anyone in your household own other real estate (including buildings, lots, farm ground, second homes)? No Yes If yes, complete the following:

Describe Property:

Owners	Address	
Date Purchased	/ /	Value of Property \$ Amount Owed \$
Is this property used as rental or income producing property?	<input type="checkbox"/> No <input type="checkbox"/> Yes	

6. Does anyone in your household have a life estate or life interest in any property? No Yes If yes, complete the following:

Describe Property:

Owners	Address	
Date the life estate created	/ /	Value of Property \$

7. Does anyone in your household have a trust? No Yes If yes, complete the following:

Type	Owners	Amount	\$
Purpose			

8. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package? No Yes If yes, complete the following:

Company	Value
---------	-------

Note: For Long Term Care assistance, the State of Texas must be named as the beneficiary of any annuity you own which was purchased on or after February 5, 2006. More information will be given to you about this process. You agree to make this assignment when you sign the application.

9. Does anyone owe you money through a promissory note or other loans? No Yes If yes, explain _____

10. Does anyone in your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc.)? No Yes If yes, complete the following:

Describe Asset	Value	\$
Owners		
Describe Asset	Value	\$
Owners		

For help completing this application, call toll free: 1-800-793-6334

What if a current member goes over their resource limit?

- Note that not all programs have a \$2,000 resource/asset limit, but many do.

For example:

- Once a member goes over the \$2,000 limit, they are supposed to report it to the Clearinghouse within 10 days. Then the Clearinghouse would have to react to it and close the case.
- The member will then need to show proof that he/she is under the \$2,000 and where the money went (proof from checking account, etc.).
- If the member spent down the excess funds fast enough, they could go over the limit and then back under the limit all in one month, and would never lose any months of eligibility.



What can you “Send down” someone’s resource on, to meet that \$2,000 limit?

- The member or their family cannot spend it on anyone other than the member/applicant. And you’ll need to show the money trail (proof of where the money went).
- You could spend it on: Clothes, Burial Plan, TV, etc. (only for the member/applicant). The correct way to spend it is on member’s needs.
- If want to talk to someone about what you can/cannot spend it on, contact the KanCare Clearinghouse at 1-800-792-4884.
- If they cannot figure out what to spend it on they can prepay Estate Recovery at 785-296-6707.

Home Ownership

- It is important to list the information about an applicant’s home.
- Does the applicant live in a facility while the spouse still lives in the home?
- Does the applicant living in a facility (nursing home, assisted living, etc.), intend to return home?
- All of these things make a difference in eligibility determination.

4. Does anyone in your household own a home? No Yes If yes, complete the following.

Owners			Address		
Date Purchased	/	/	Value	\$	Amount Owed \$
Who lives in the home?					
If the owner does not live there, explain why:					
If the owner does not live there, does the owner intend to return home?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If yes, when?					

**P8, Lines
4a-4f**

5/3/2020

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The state does not count the following as assets:

- the home where you live (or the land that it sits on)
- one car
- some burial plans
- furniture and household items

What if the applicant is living in a Nursing Home (or some other LTC facility)?

- When answering the question, “If the owner does not live there, does the owner intend to return home?”
- What if the applicant living in the nursing home miraculously gets better, would they return to this home?
- If they would want to return home, even if it is wasn’t very likely, it is appropriate to answer this question yes.

P8, Lines 4c-4f

Who lives in the home?	
If the owner does not live there, explain why:	
If the owner does not live there, does the owner intend to return home?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when?	

3/8/2020

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Regarding Nursing Facility coverage: Single persons must have assets below \$2000. We will not count the value of the home if the person intends to return home.

What happens if an individual ends up in the NF for over 3 months?

If someone is in a LTC facility for 3 months, at month 4, they are considered permanent,“ regardless if they intend/hope to return home if they make a miraculous recovery.

Answer: They can mark on the application whatever they like (temporary or permanent stay); if it turns from a temp stay to a permanent stay, KanCare will change the coding at that time.

Other Real Estate

- This question does **not** include the land that the applicant's primary residence sits on.
- If they own other land or buildings, please document that here.

5. Does anyone in your household own other real estate (including buildings, lots, farm ground, second homes)? No Yes If yes, complete the following.

P8, Lines 5a-5d

Describe Property					
Is this property used as rental or income producing property?	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Owners		Address			
Date Purchased	/	/	Value	\$	Amount Owed: \$

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The state does not count the following as assets:

- the home where you live (or the land that it sits on)
- one car
- some burial plans
- furniture and household items

Life Estate or Life Interest in any Property?

- If the applicant has no idea what this is, most likely they do **not** have one.
- What is a Life Estate? It is a form of joint ownership that allows one person to remain in a home until his/her death. Then the home passes to another owner.

6. Does anyone in your household have a life estate or life interest in any property? No Yes

If yes, complete the following.

Describe Property			
Owners		Address	
List date life estate created:	/ /	Value of Property	\$

P8, Lines 6a-6c

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Do you have a TRUST?

- If the applicant owns a **trust**, document it here.
- But it is also important to **document all the assets that are part of the trust on page 7** (*Tell us about your Resources* section) of the application as well.
- If marked **yes**, KDHE will need a **full copy of the entire trust along with all the schedules**.

7. Does anyone in your household have a trust? No Yes If yes, complete the following.

Type	Owners	Amount	\$
Purpose			

P8, Lines 7a-7b

3/3/2020

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Investments/Annuities

- This section describes annuities owned by the applicant or their spouse.
- If the individual owns an annuity, the state of Kansas must be named as the beneficiary of any annuity which they own that was purchased on or after February 8, 2006.
- **The individual agrees to make this assignment once they sign the application.**

8. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package? No Yes If yes, complete the following.

Owners		Value	
Company			

P8, Lines 8a-8b

What is an annuity?

An annuity is a fixed sum of money paid to someone each year, typically for the rest of their life. It might be an inheritance passed down or a form of insurance or investment.

Annuity Examples:

- "He left her an annuity of \$1,000 in his will."
- The investor is entitled to a series of annual sums from "an annuity plan."

Does Someone Owe You Money?

For example:

Did the applicant loan someone \$8,000 six months ago?

9. Does anyone owe you money through a promissory note or other loans? No Yes
If yes, explain _____

P8, L9

Other Assets

10. Does anyone in your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc.)? No Yes If yes, complete the following.

Describe Asset			
Owners		Value	\$
Describe Asset			
Owners		Value	\$

P8, Lines 10a-10d

This would include things such as:

- *Motorcycles*
- *Trailers*
- *Livestock*
- *Tractors*
- *R.V.s*
- *Oil Rights*
- *Farm equipment*
- *Boats*
- *Machinery*

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11. Have you or your spouse taken a loan against any property in the last five years, including a second mortgage or reverse mortgage? No Yes
12. Have you or your spouse ever waived rights to an inheritance or will? No Yes
13. Have you or your spouse ever worked with an attorney or other professional for Estate Planning purposes? No Yes. If yes, complete the following.

Name of Attorney	Date	/	/
------------------	------	---	---

14. Have you or your spouse sold, traded, given away or changed ownership of any property such as a house or money, or any other property in the last 5 years? No Yes. If yes, complete the following:

Date Ownership Changed	Type of Property	Value	Given/Sold to	Purpose
/ /		\$		
/ /		\$		
/ /		\$		

F. Tell us about your Earned Income

Does anyone in your household have a job? No Yes. If yes, answer the questions below.

	JOB 1	JOB 2	JOB 3
Worker's Name			
Company Name			
Company Address			
Company Phone			
Start Date	/ /	/ /	/ /
How many hours working per week?			
Spouse Salary or hourly wage	\$	\$	\$
How often are they paid?			
Date of next paycheck?	/ /	/ /	/ /
Do any of these jobs include tips, commissions or bonuses? If yes, answer the questions below.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
What type?			
What is the usual amount? (Include deductions)	\$	\$	\$
How often?			

Have you take a loan against any property in the last 5 years?

- Have you or your spouse taken out a loan against any property in the last 5 years, including a second mortgage or reverse mortgage?
- **Reverse Mortgage** – a loan available to homeowners 62 years or older that allow them to convert part of the equity in their home into cash.
- If the individual has one, the eligibility team will need the contract from the reverse mortgage that shows the gross amount of money they get from it.

11. Have you or your spouse taken a loan against any property in the last five years, including a second mortgage or reverse mortgage? No Yes

P9, L11

Did you waive any rights?

12. Have you or your spouse ever waived rights to an inheritance or will?

Yes

No

P9, L12

Estate Planning Attorneys/Professionals?

- Estate Planning is the process of arranging during a person's life for the disposal of their estate.
- If the applicant has paid for someone to help them manage assets, list those professionals here.

13. Have you or your spouse ever worked with an attorney or other professional for Estate Planning purposes?

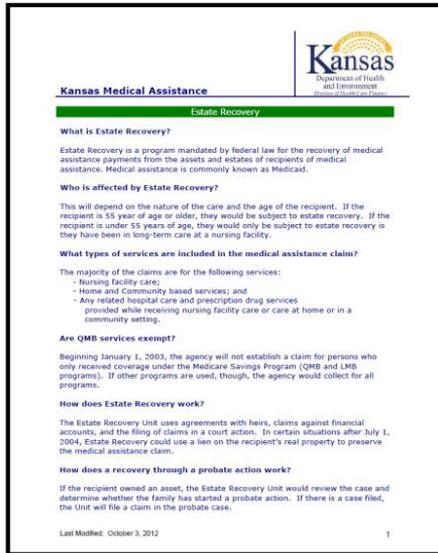
No Yes If yes, complete the following.

Name of Attorney		Date	/	/
------------------	--	------	---	---

P9, L13

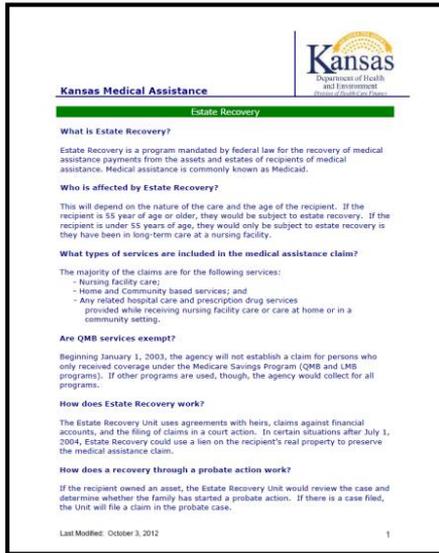
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Fact Sheet: Estate Recovery



- The estate recovery program recovers assets from some estates (from the estates of certain deceased Medicaid members).
- This may include estates of persons age 55 or older.
- It also may include estates of persons who received long term care services.

Fact Sheet: Estate Recovery



The majority of the claims are for the following services:

- Nursing facility care
- Home and Community based services
- Any related hospital care and prescription drug services provided while receiving nursing facility care or care at home or in a community setting.

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How do I contact Estate Recovery?

To contact Estate Recovery:

Call 785-296-6707

E-mail to eeseru@khpa.ks.gov

Mail to:

Estate Recovery Unit

P.O. Box 2428 Topeka, KS. 66601

To contact the contractor, Health Management Systems:

Call 800-817-8617

E-mail to: KSestaterecovery@hms.com

Fax to 646-465-6530

Sold, Traded, Gifted, Changed Ownership of Property in the last 5 Years?

- Please document any change in ownership of any property within the last 5 years in this section.
- For example: sale of vehicles, or transferring resources to a trust fund, giving assets to family members.

P9, Lines 14a-14c

14. Have you or your spouse sold, traded, given away or changed ownership of any property such as a house or money, or any other property in the last 5 years? No Yes If yes, complete the following.

Date Ownership Changed	Type of Property	Value	Given/Sold to	Purpose
/ /		\$		

Important note on Transferring Property for Less Than Fair Market Value:

- Gifting, selling or transferring property for less than fair market value can result in a period of ineligibility for Long Term Care coverage (Programs: Nursing Home, HCBS, and PACE).
- The KDHE Eligibility Team must look back for transfers within the last 5 years.
- For a Nursing Home, the amount of penalty divided by about \$5,000 = months of no eligibility

Example:

A parent gifted their child their \$100,000 home; \$100,000 divided by \$5,000 = 20 months of ineligibility in a nursing home.

*That member might be found eligible for the Medically Needy program during that 20 months, but they would not be eligible for the NF program for that 20 months (penalty time).

Earned Income (Wages Earned from a Job)

P9, Lines F1-F16

F. Tell us about your Earned Income		
Does anyone in your household have a job? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, answer the questions below		
	Job 1	Job 2
Worker's Name		
Company name		
Company Address		
Company Phone		
Start Date	/ /	/ /
How many hours working per week?		
Gross Salary or hourly wage	\$	\$
How often are they paid?		
Date of next paycheck?	/ /	/ /
Do any of these jobs include tips, commissions or bonuses? If yes, answer the questions below.		
	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
What type?		
What is the usual amount? (before deductions)	\$	\$
How often?		

- You'll need to submit the last 30 days of **paystubs**.
- If the person does **not** have their paystubs, they need to ask for a **print out of their gross wages and the date they received these wages** from the employer.
- **A W-2 will NOT be accepted.**

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Asking for Help Paying Medical Bills for the Past Three Months?

- If asking for assistance to pay medical bills for 3 months prior to the date of the application, the eligibility team will need the paystubs for those 3 months prior to the date of the application.
- For example, if I am applying in April, and ask for prior medical help, the applicant will need to send in the paystubs for January, February, March and the paystubs they have for April.

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Is anyone in your household self-employed? No Yes. If yes, answer the questions below.
Self-employed means this person is their own boss. This includes odd jobs, childcare, lawn mowing, snow removal, cosmetic sales, rental income, etc., even if it is not your primary job.

	Self-employed 1	Self-employed 2	Self-employed 3
Name of self-employed person			
Business Name			
What type of business is it?			
When did the business start?			
Where taxes filed on this income last year?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
What IRS form did you file for this income?	<input type="checkbox"/> Schedule C	<input type="checkbox"/> Schedule C	<input type="checkbox"/> Schedule C
	<input type="checkbox"/> Schedule D	<input type="checkbox"/> Schedule D	<input type="checkbox"/> Schedule D
	<input type="checkbox"/> Schedule E	<input type="checkbox"/> Schedule E	<input type="checkbox"/> Schedule E
	<input type="checkbox"/> Schedule F	<input type="checkbox"/> Schedule F	<input type="checkbox"/> Schedule F
	<input type="checkbox"/> 4797	<input type="checkbox"/> 4797	<input type="checkbox"/> 4797
	<input type="checkbox"/> 3065	<input type="checkbox"/> 3065	<input type="checkbox"/> 3065
	<input type="checkbox"/> 1120S	<input type="checkbox"/> 1120S	<input type="checkbox"/> 1120S
<input type="checkbox"/> Schedule K	<input type="checkbox"/> Schedule K	<input type="checkbox"/> Schedule K	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	
Reported Annual Gross Income	\$ _____	\$ _____	\$ _____
Reported Annual Gross Expenses	\$ _____	\$ _____	\$ _____
Estimated monthly income (before expenses)	\$ _____	\$ _____	\$ _____
Monthly expenses	\$ _____	\$ _____	\$ _____

Tell us about your Work Expenses
If you are disabled and working, list any expenses related to your disability which allow you to work. Examples: specialized transportation to and from work, attendant care to help you get ready for work, service animals, medications, specialized equipment or tools.

	Person 1 Youself		Person 2		Person 3	
	<input type="checkbox"/> No <input type="checkbox"/> Yes					
Does the person have income from working?						
If yes, list any expenses related to your disability which allow you to work.	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
		\$ _____		\$ _____		\$ _____
		\$ _____		\$ _____		\$ _____

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Self-Employment Income?

Name of self-employed person	
Business Name	
What type of business is it?	
When did the business start?	
Were taxes filed on this income last year?	<input type="checkbox"/> No <input type="checkbox"/> Yes
What IRS form did you file for this income?	<input type="checkbox"/> Schedule C <input type="checkbox"/> Schedule D <input type="checkbox"/> Schedule E <input type="checkbox"/> Schedule F <input type="checkbox"/> 4797 <input type="checkbox"/> 1065 <input type="checkbox"/> 1120S <input type="checkbox"/> Schedule K <input type="checkbox"/> Other _____
Reported Annual Gross Income	\$
Reported Annual Gross Expenses	\$
Estimated monthly income (before expenses)	\$
Monthly expenses	\$

P10, L1-12

- There are several types of **self employment income** that may be received by an applicant or their spouse.
- **For example:** odd jobs, childcare, snow removal, rental income (even if it's not your primary job)
- If the applicant or spouse is self-employed the eligibility team will need their **last tax return**. This will need to be **the entire return**, not just certain schedules.

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A few examples include:

- Income from farming
- Income received from leasing or renting farmland
- Income received from leasing or renting a home or other property

If applicant has a disability and is working, are there work expenses?

	Person 1 Yourself	
Does this person have income from working?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, list any expenses related to your disability which allows you to work.	Type of Expense	Monthly Amount
		\$
		\$
		\$

P10, L13-16

Examples:

- Specialized transportation to and from work
- Attendant care at work
- Attendant care to help you get ready for work
- Service animals
- Medications
- Specialized Equipment or tools

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G. Tell us about your Other Income
Complete the following chart. Mark no or yes on each item below.

Type/Source of Income	Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Oil Royalties/Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$		

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Other Income (Unearned Income)

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

P11, Section G, L1-18

- This is about **income** that is **not received from a job or self-employment** (unearned)
- List the **gross amount received before taxes** or other deductions.
- **For example:** Social Security Benefits, VA Benefits, etc.

It is important to list the income of the applicant and the applicant's spouse. (The eligibility team requires this when determining allocation of income to the community spouse.)

Providing the spouse's income **and verification of income** will help speed up the determination process.

Other Income

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	Annually	
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	1 Time Lump Sum	
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	Monthly	
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	Weekly	
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	Monthly	
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

- Most of these will likely be monthly payment.
- Include **lump sum** payments too!

Possible Examples:

- Weekly
- Bi-Weekly
- Monthly
- Annually
- 1 – Time Lump Sum

**P11,
L1-18**



The focus is on “recurring payments.”

“**Lump sum payments**” are treated differently, but still need to be listed here.

Social Security Income & Supplemental Security Income

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1 _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2 _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

Please list the amounts for any:

1. Social Security Benefits
2. Supplemental Security Income (SSI)

P 11, L 2-3

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The eligibility team is able to obtain the Social Security Income amounts directly from the Social Security Administration.

Veteran's Benefits

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

P11, L 4

Please provide a letter from the VA that lists:

1. The type of Veterans benefit
2. The current amount

For help getting this information, contact your local KS Commission on Veterans' Affairs office:

<https://kcva.ks.gov/veteran-services/office-locations>



If the applicant is a veteran, or spouse or widow of a veteran KDHE Eligibility Team must have (1) verification that the applicant has applied with the VA for these cash benefits, or (2) a letter stating that they are not eligible for cash benefits.

Who can help me get this documentation?

The local *KS Commission on Veterans' Affairs* offices across Kansas can help people determine if they are eligible to apply, and if not, can write a letter saying that they are not. **KS Commission on Veterans' Affairs local office locations:** <https://kcva.ks.gov/veteran-services/office-locations>

What type of documentation will the KS Commission on Veterans' Affairs need to help me find out whether or not I am eligible for VA benefits? You'll need the veteran's "Discharge Papers." For the Korean War or after, it will most likely be the DD214 (Discharge Papers). If you cannot find the discharge papers, the KS Commission on Veterans' Affairs can help you get those papers. However, you will need to know "when the veteran served."

If they are eligible, KDHE needs a Verification Letter from the VA regarding VA Benefits:

1. Type of benefit
2. Current amount of benefit

Railroad Retirement & Trust Payments

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1 _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2 _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

P 11, L 5-6

- Please provide a letter from the Railroad Retirement Board which lists the current amount.
- Verification of payments received from a trust must be provided.

Oil Royalties or Mineral Rights

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

Please provide the **tax return** to verify any income earned from oil royalties or mineral rights.

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Contract Sale

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

P 11, L 13

- A contract sale is a contract in which a **property title is transferred only after a buyer makes a certain number of monthly payments.**
- **If an applicant is receiving payments this is considered income** and the eligibility team must have verification of the Contract Sale and the income being received.

Rental Income

Type/Source of Income		Name of Person who receives this	Amount Received	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Retirement or Pension Source	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Oil Royalties/ Mineral Rights	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Contract Sale	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Child Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Spousal Support	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 1	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other Income Source 2	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

If the applicant or spouse owns property or a home and it is being rented, the eligibility team needs verification of the **amount received from the rental.**

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Note: *Income producing property* would be exempt as an asset if you're getting income on it (income must be a fair market value amount, and you would have to have reported the income here).

KDHE won't count something as "income" and then count it again as an "asset." Explanation: A resource shall not be considered as a resource *and* as income in the same month. For example, when income received in a month is deposited into a checking or savings account, the value of such account for that month shall be determined by subtracting the total amount of income deposited from the lowest balance of the account.

Page 12 - Other Health Insurance

H. Tell us about your Medical Insurance

Health Insurance Policy Information
 Answer the questions below for everyone who has Medicare or other health insurance.

	Person 1 Yourself?	Person 2	Person 3
First and Last Name			
Does this person have Medicare? If yes, answer the questions below	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicare Claim #			
Medicare Part A?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part A Effective Date	/ /	/ /	/ /
Part A Premium Amount	\$ / /	\$ / /	\$ / /
Medicare Part B?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part B Effective Date	/ /	/ /	/ /
Part B Premium Amount	\$ / /	\$ / /	\$ / /
Medicare Part C? (Medicare Advantage)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part C Effective Date	/ /	/ /	/ /
Part C Premium Amount	\$ / /	\$ / /	\$ / /
Part C Plan Name			
Medicare Part D?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part D Effective Date	/ /	/ /	/ /
Part D Premium Amount	\$ / /	\$ / /	\$ / /
Part D Plan Name			
Answer the questions below for everyone who has insurance OTHER than Medicare.			
Does this person have other health insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ends	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage	<input type="checkbox"/> Catastrophic Only <input type="checkbox"/> Dental <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	<input type="checkbox"/> Catastrophic Only <input type="checkbox"/> Dental <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	<input type="checkbox"/> Catastrophic Only <input type="checkbox"/> Dental <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Other _____

For help completing this application, call toll free: 1-800-792-8884

For example:

- Medicare
- Medicare Supplemental Insurance
- Other Health Insurance

❖ **Not asking about Medicaid here**

Do you have Medicare?

H. Tell us about your Medical Insurance

Health Insurance Policy Information			
Answer the questions below for everyone who has Medicare or other health insurance			
	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Does this person have Medicare? If yes, answer the questions below	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicare Claim #			
Medicare Part A?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part A Effective Date	/ /	/ /	/ /
Part A Premium Amount	\$	\$	\$
Medicare Part B?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part B Effective Date	/ /	/ /	/ /
Part B Premium Amount	\$	\$	\$
Medicare Part C? (Medicare Advantage)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part C Effective Date	/ /	/ /	/ /
Part C Premium Amount	\$	\$	\$
Part C Plan Name			
Medicare Part D?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part D Effective Date	/ /	/ /	/ /
Part D Premium Amount	\$	\$	\$
Part D Plan Name			

P12, Section H, Lines 1-19

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- Answer the questions the best you and the applicant can.
- You can find many answers on the Medicare card or the applicant can call the phone number on the card for answers to these questions.

Note: The KDHE eligibility team has connections with Medicare and can find out most of the Medicare effective dates for you.

Health Insurance (Other than Medicare)

Answer the questions below for everyone who has insurance OTHER than Medicare.		
Does this person have other health insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Policyholder's name		
Policyholder's SSN		
Insurance Company Name		
Insurance Company Address		
Date Began	/ /	/ /
Date Ended	/ /	/ /
Policy #		
Group #		
Type of Coverage	<input type="checkbox"/> Catastrophic Only <input type="checkbox"/> Dental <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/>	<input type="checkbox"/> Catastrophic Only <input type="checkbox"/> Dental <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Other _____

P12, Section H, L 20-30

The eligibility team needs the applicant to submit:

1. A copy of the front and back of the insurance card
2. Proof of the monthly premium the applicant pays

❖ Other than Medicare

❖ Other than Medicaid



With private insurance, such as Blue Cross Blue Shield (BCBS) use the bottom section to document any private health insurance policies the applicant may have.

Private Health Insurance may include:

- Medicare Supplemental Health Insurance Policies
- Health Insurance through an employer
- Long Term Care Insurance

*Providing the eligibility team with the monthly premium amounts will lower a person's **monthly Patient Liability/Client Obligation (the monthly cost share** the KanCare member must pay for his/her share in the cost of medical services).

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KC1500
11/18

I. Tell Us About Your Dependents and Household Expenses

Complete this section only if applying for HCBS or institutional care. You may be able to protect a portion or all of your own income for your dependents. If you have a spouse or minor child that is part of your household that you have not already told us about, go back to Section C and answer the questions.

Dependents
If you have minor children that don't live with you or you have another family member who is dependent on you, please complete the following:

Name of individual	Relationship to you	Date of Birth	Individual's monthly income	If a child, who does the child live with?	If a child and living with another parent, list the monthly income of the parent
		/ /	\$		\$
		/ /	\$		\$
		/ /	\$		\$

Household Expense

List monthly dollar expenses below for the spouse at home.

Type of Expense	How often?	Amount
1. Rental Cost / Lot Rent		\$
2. Mortgage Payment		\$
3. Property Taxes (if not included in #2 above)		\$
4. Home Insurance (if not included in #2 above)		\$
5. Other (condominium/home owners association fees)		\$

Choose Your Health Plan
Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please review the Extra Services Highlights flyer and choose your plan. If you choose, we will enroll you in that plan if eligible 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. For more information about these plans, visit www.KanCare.ks.gov
Note: For persons who are not eligible for a KanCare plan, information about coverage and services will be sent separately.



Dependents

Complete this section only if applying for HCBS or institutional care. You may be able to protect a portion or all of your own income for your dependents. If you have a spouse or minor child that is part of your household that you have not already told us about, go back to Section C and answer the questions.

Dependents					
If you have minor children that don't live with you or you have another family member who is dependent on you, please complete the following:					
Name of Individual	Relationship to you	Date of Birth	Individual's monthly income	If a child, who does the child live with?	If a child and living with another parent, list the monthly income of the parent
		/ /	\$		\$
		/ /	\$		\$
		/ /	\$		\$
Household Expense					
List monthly shelter expenses below for the spouse at home.					
Type of Expense	How Often?		Amount		
1 Rental Cost / Lot Rent			\$		
2 Mortgage Payment			\$		
3 Property Taxes (if not included in #2 above)			\$		
4 Home Insurance (if not included in #2 above)			\$		
5 Other (Condominium/Home Owners Association fees)			\$		

P13, Section I, Lines 1-12

Complete this section if the applicant wants coverage for care in a Nursing Facility (Institutional Care), Assisted Living Facility (which qualifies as HCBS) or other HCBS Waivers or PACE and has “dependant family members.”

Verification of reported shelter expenses for “dependents” must be provided.

A dependant family member could include:

- Spouse
- Minor Child
- Other family member

Dependency may be of any kind:

- Legal
- Financial
- Medical

Don't Have Dependents and Not applying for HCBS, Nursing Facility or PACE?

Complete this section only if applying for HCBS or institutional care. You may be able to protect a portion or all of your own income for your dependents. If you have a spouse or minor child that is part of your household that you have not already told us about, go back to **Section C** and answer the questions.

Dependents					
If you have minor children that don't live with you or you have another family member who is dependent on you, please complete the following:					
Name of Individual	Relationship to you	Date of Birth	Individual's monthly income	If a child, who does the child live with?	If a child and living with another parent, list the monthly income of the parent
NA		/ /	\$	NA	
NA		/ /	\$	NA	
NA		/ /	\$	NA	
Household Expense					
List monthly shelter expenses below for the spouse at home.					
Type of Expense	How Often?		Amount		
1 Rental Cost / Lot Rent			NA		
2 Mortgage Payment			NA		
3 Property Taxes (if not included in #2 above)			NA		
4 Home Insurance (if not included in #2 above)			NA		
5 Other (Condominium/Home Owners Association fees)			NA		



You only need to complete this section if applying for one of the Long Term Care programs (HCBS, Nursing Facility, or PACE) and you have dependents.

Otherwise, mark NA for Non-Applicable in this section.

Don't forget to choose a Health Plan

Go to the KanCare website at www.KanCare.ks.gov, then select the [Benefits & Services](#) link, to find the [Health Plan Highlights](#) .

Choose Your Health Plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please review the Extra Services Highlights flyer and choose your plan. If you choose, we will enroll you in that plan if eligible 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. For more information about these plans, visit www.KanCare.ks.gov

Note: For persons who are not eligible for a KanCare plan, information about coverage and services will be sent separately.

 Aetna Better Health® of Kansas	 sunflower health plan.	 UnitedHealthcare®
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3/3/2020 **P13, L13**

If this is left blank, a health plan (MCO/Managed Care Organization) will be chosen for the consumer.

Keep in mind when choosing which MCO:

- If not in a nursing home, make sure it is an MCO (Managed Care Organization) or Health Plan that your favorite provider accepts.
- Check out the Health Plan Highlights on the KanCare website to compare and contrast the “Extra Services or Value Added Services” that each MCO offers. Does one MCO have more of the “Extra Services” that would be a better fit for you?

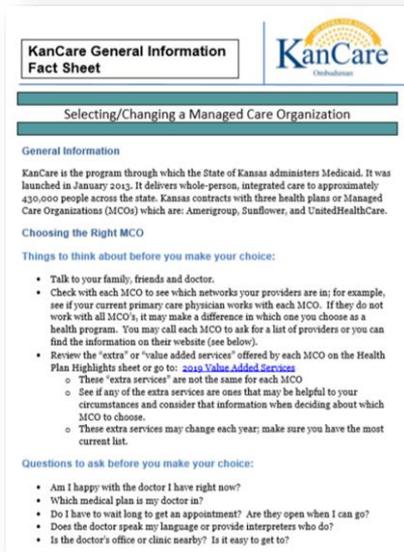
URL for the Benefits & Services webpage:

<http://www.kancare.ks.gov/consumers/benefits-services>

Note to Nursing Homes:

Make sure it is an MCO (Managed Care Organization) or Health Plan that your facility accepts.

Selecting/Changing a Managed Care Organization



- For more information on how to select and change a Managed Care Organization (MCO)...
- Check out the **KanCare Ombudsman's General Information Fact Sheets** webpage at: www.kancare.ks.gov/kancare-ombudsman-office/kancare-general-information-fact-sheets



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J. Choose Someone to Help You With Your Medical Assistance Case

Primary Applicant. If you are completing this application on behalf of someone for whom you are the Guardian, Conservator, Financial Power of Attorney or Social Security Payee, please complete the information below and submit proof.

First and Last Name			
Address Line 1			
Address Line 2			
City	State	Zip Code	
Phone Number	Email Address		

You can name a person to help you with your medical assistance case. You can choose either a "Medical Representative" or a "Facilitator."

Medical Representative is a person who can sign your application, answer questions for you, and use your medical assistance card for you. We will share information with this person. This person will get copies of letters sent to you about your case. This person is responsible for completing your review each year and for telling us about changes in your situation. The Medical Representative can be a relative, neighbor, friend, or other person you trust. You may not name someone who is trying to collect a medical debt against you.

Facilitator is a person who can help you fill out your application and help you through the application process. We will be able to share information with this person. This person will get copies of letters sent to you about your application. After your application is processed, this person is not connected to your case. A facilitator can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.

I want to appoint the following person to help me.

First and Last Name			
Organization Name			
Address Line 1			
Address Line 2			
City	State	Zip Code	
Phone Number	Email Address		

What is this person's relationship to you? (for example: child, friend, neighbor, etc)

I appoint the above named person to be my Medical Representative, or Facilitator.

Signature	Date
Witness signatures are required if the signature above is made with a mark.	
Witness	Date
Witness	Date

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If you are completing this application on behalf of someone else:

- If you are their Guardian, Conservator, their Social Security Payee, their Power of Attorney...
- Please complete this section and submit proof.

J. Choose Someone to Help You With Your Medical Assistance Case

P14, Section J, L 1-6

Primary Applicant - If you are completing this application on behalf of someone for whom you are the Guardian, Conservator, Financial Power of Attorney or Social Security Payee, please complete the information below and submit proof.

First and Last Name			
Address Line 1			
Address Line 2			
City	State	Zip Code	
Phone Number	Email Address		

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If a family member, friend or neighbor is helping someone to complete the application:

They may choose to allow the KanCare applicant to appoint them as their Medical Representative or Facilitator.

You can name a person to help you with your medical assistance case. You can choose either a "Medical Representative" or a "Facilitator."

P14, Section J, Lines 7-19

I want to appoint the following person to help me.

First and Last Name			
Organization Name			
Address Line 1			
Address Line 2			
City	State	Zip Code	
Phone Number	Email Address		
What is this person's relationship to you? (for example: child, friend, neighbor, etc)			
I appoint the above named person to be my <input type="checkbox"/> Medical Representative, or <input type="checkbox"/> Facilitator.			

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Medical Representative

- The Medical Representative can be a relative, neighbor, friend, or other person you trust.
- You may **not** name someone who is trying to collect a medical debt against you.

Medical Representative is a person who can sign your application, answer questions for you, and use your medical assistance card for you. We will share information with this person. This person will get copies of letters sent to you about your case. This person is responsible for completing your review each year and for telling us about changes in your situation. The Medical Representative can be a relative, neighbor, friend, or other person you trust. **You may not name someone who is trying to collect a medical debt against you.**

P14, Section J, Lines 7-19

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Note to Nursing Homes:

It is recommended that everyone in a nursing home have a Medical Representative listed on the application.

However, **employees of nursing facilities *cannot* be medical representatives** because the nursing home is trying to collect a debt against the applicant.

What can a Medical Representative do?

- Sign the KanCare application
- Answer questions for applicant
- Use the medical assistance card for the KanCare member
- KanCare will share information with this person.
- This person will get copies of letters sent to the applicant or member about their case.
- This person will get copies of the member's **annual review** form and **is responsible for completing this review each year and for telling KanCare about changes in the applicant's or member's situation** (address changes, income changes, etc.).

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The annual review and updating KanCare Clearinghouse about changes in the member's situation are extremely important in keeping a person's case open.

Medical Representative Authorization Form

Kansas
Department of Health
and Senior Services
Division of Health Care
Administration

P.O. Box 3599
Topeka, KS 66601-0738
Phone: 1-800-792-4884

Medical Representative Authorization Form

Consumer Name: _____
Consumer ID or SSN: _____

You can name a person to help you with your medical assistance case. This form is used to appoint a Medical Representative.

A Medical Representative is a person who can apply for you, talk about your case with KanCare, send in papers requested, and use your medical card for you. They will get copies of letters about your case. They have to send in your review each year and tell us about changes in your situation. Your Medical Representative can ask for a Fair Hearing or an appeal for you. They can also go with you to a hearing or represent you at the hearing.

You can name a relative, neighbor, friend, or other person you trust to do this for you. They cannot be someone who is trying to collect a medical debt against you.

This person will remain your medical representative until you tell us to remove them.

First and Last Name	_____		
Address Line 1	_____		
Address Line 2	_____		
City	State	Zip Code	
_____	_____	_____	
Phone Number	Email Address	_____	
_____	_____	_____	

What is this person's relationship to you? (For example: child, friend, neighbor, etc.) _____

I authorize the use or disclosure of my health information by the person named above to KDHE, DHCF, DCF, and KDADS.
I understand that I have the right to revoke this authorization at any time by notifying KDHE, DHCF, and KDADS.
I understand that this authorization will continue until I either revoke this authorization or appoint a different person to serve as my Medical Representative.
I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
I understand that I am entitled to a copy of this authorization.

My signature on this form signifies that I have read and understand the conditions above.

Signature: _____ Date: _____
Witness signatures are required if the signature above is made with a mark.

Witness: _____ Date: _____
Witness: _____ Date: _____

Fax completed form to: Family Medical programs 1-800-498-1255 or Elderly & Disabled Medical programs 1-844-264-6285

KS08100

- What if I need to be this applicant's or member's Medical Representative, but I didn't get signed up at the time of application?
- You'll need a completed [Medical Representative Authorization Form](#) submitted to the Clearinghouse, before they will speak to you about the individual's case.

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This is the same form you would need if representing someone in a state fair hearing as well.

URL for *The Medical Representative Form*:

<http://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy/policy-appendix>

Facilitator – more limited authority to assist applicant or member

- Can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.
- Cannot complete an application or request services on behalf of an applicant, but they can help the applicant fill out your application and help them through the application process.

P14, Section J, Lines 7-19

Facilitator is a person who can help you fill out your application and help you through the application process.

We will be able to share information with this person. This person will get copies of letters sent to you about your application. After your application is processed, this person is not connected to your case. A facilitator can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.



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- May be someone who is collecting a medical debt against the applicant or member, such as nursing home or other medical office staff.
- **An employee of a nursing facility can be a Facilitator** without signing a release of information form by filling out this portion of the application.

What can a Facilitator do?

- KanCare will be able to share information with this person.
- This person will get copies of all letters, forms and notices sent to the applicant regarding their application.
- This **Facilitator Appointment** will last through the end of the application period.
- After the application has been processed, this person will no longer be connected to your case.

3/3/2020



Note to Nursing Facilities:

- After the application has been processed, and the “Facilitator” appointment has expired, it is not required that the nursing facility submit a new “release of information” form.
- The nursing facility will still be able to call the KanCare Clearinghouse and receive information about the status of the application, dates of eligibility decisions, and coverage effective dates, patient liability amount, and name and contact information about the MCO.
- Additionally, the nursing facility will also receive notices to inform them of changes to an individual’s patient liability.

Facilitator Authorization Form

Kansas
Department of Health and Senior Services

P.O. Box 3559
Topeka, KS 66601-0759
Phone: 1-800-752-4884

Facilitator Authorization Form

Consumer Name: _____
Consumer ID or SSN: _____

You can name a person to help you with your medical assistance application. This form is used to appoint a Facilitator.

A Facilitator is a person or organization who can help you fill out your application and help you through the application process. You remain in charge of your care. We will be able to share information with this person. They will get copies of letters sent to you about your application. You have the option to tell us how long you want the information to be shared (see below). This release will stay in effect until your application is completed. A Facilitator can be a relative, neighbor, friend, medical office staff, or community organization employee.

They cannot make request for coverage for you.

First and Last Name	_____
Organization Name	_____
Address Line 1	_____
Address Line 2	_____
City	_____
State	_____
Zip Code	_____
Phone Number	_____
Email Address	_____

What is this person's relationship to you? (For example: child, friend, neighbor, medical provider, community organization, etc.) _____

I authorize the use or disclosure of my health information by the person named above to KDHE-DHCF, DCF, and KDAOS.
I understand that I have the right to revoke this authorization at any time by notifying KDHE-DHCF.
I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
I understand that I am entitled to a copy of this authorization.
I understand that this authorization will expire 6 months from the date this form is signed or once my application is completed, whichever is later. I choose to provide a different date for the expiration of this release: _____
An appointment of a community organization, a medical provider, or staff cannot exceed 12 months.

My signature on this form signifies that I have read and understand the conditions above.

Signature: _____ Date: _____

Witness signatures required if the signature above is made with a mark.

Witness: _____ Date: _____
Witness: _____ Date: _____

Fee completed form to: Family Medical programs 1-800-438-1255 or Elderly & Disabled Medical programs 1-844-264-6295
408220

- What if I need to be this applicant's or member's Facilitator, but I didn't get signed up at the time of application?
- You'll need a completed [Facilitator Authorization Form](#) submitted to the Clearinghouse, before they will speak to you about the individual's case.

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The URL for *The Facilitator Form*: <http://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy/policy-appendix>

Facilitator Form - Expiration Date

- The facilitator authorization form expires 6 months from the date the form is signed, or once the application is completed, whichever is later.
- Or, the applicant/member can choose a different date.
- A facilitator appointment of a community organization, medical provider, or staff cannot exceed 12 months.

I understand that this authorization will expire 6 months from the date this form is signed or once my application is completed, whichever is later. I choose to provide a different date for the expiration of this release: _____.
An appointment of a community organization, a medical provider, or staff cannot exceed 12 months.

My signature on this form signifies that I have read and understand the conditions above.

Signature: _____

Date: _____

What if KanCare won't talk to me?

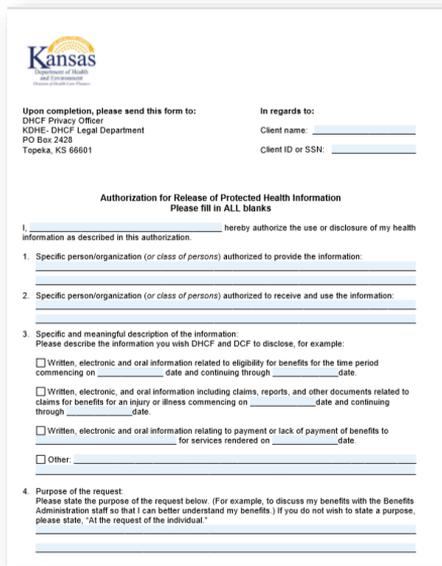


- Generally speaking, if an applicant or member needs someone to communicate with KanCare on their behalf so they can get or keep their services, the person helping them needs to be their guardian, conservator, Medical Representative, or hold DPOA.
- They must also have submitted documentation proving this to the KanCare Clearinghouse.

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KDHE Release of Information Form



The image shows a form titled "Authorization for Release of Protected Health Information" from the Kansas Department of Health and Senior Services. The form includes contact information for the DHCF Privacy Officer and fields for client name and ID/SSN. It contains several numbered sections for providing authorization details, including specific persons authorized to provide or receive information, a detailed description of the information to be released (with checkboxes for eligibility, injury/illness, and payment information), and a section for the purpose of the request.

Upon completion, please send this form to: DHCF Privacy Officer, KDHE, DHCF Legal Department, PO Box 2438, Topeka, KS 66601. In regards to: Client name: _____, Client ID or SSN: _____.

Authorization for Release of Protected Health Information
Please fill in ALL blanks

I, _____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information: _____

2. Specific person/organization (or class of persons) authorized to receive and use the information: _____

3. Specific and meaningful description of the information:
Please describe the information you wish DHCF and DCF to disclose, for example:
 Written, electronic and oral information related to eligibility for benefits for the time period commencing on _____ date and continuing through _____ date.
 Written, electronic, and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _____ date and continuing through _____ date.
 Written, electronic and oral information relating to payment or lack of payment of benefits to _____ for services rendered on _____ date.
 Other: _____

4. Purpose of the request:
Please state the purpose of the request below. (For example, to discuss my benefits with the Benefits Administration staff so that I can better understand my benefits.) If you do not wish to state a purpose, please state, "At the request of the individual." _____

- Another option is that the applicant or member **chooses** to add an individual or organization to the [KDHE Release of Information \(ROI\) form](#), so they will be able to communicate with KanCare about their case.
- If the applicant or member has other loved ones (for example, other children or family members) that **need to be able to communicate with the KanCare Clearinghouse directly about their case.**
- This form must be completed by the applicant or member, and submitted to the Clearinghouse.

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KDHE Release of Protected Health Information Form, URL:
http://www.kdheks.gov/hcf/data_requests/download/KDHEReleaseofPHI_EN.pdf

What if the applicant or member cannot make this choice?



Issue:

- What if the applicant or member who needs your help is unable to make decisions for themselves...
- AND they don't have a legal guardian, DPOA or Medical Representative?
- Staff members, neighbors or friends trying to help them **cannot** fill out an ROI **for them**, even with the best intentions. Doing so would be without the actual decision being made by the individual.

How can I help them?

Resolution: (per Kansas Guardianship Program)

- The person trying to help the applicant or member (provider, friend, neighbor, etc. who is not a guardian, Medical Representative, etc.) can contact the **Adult Protective Services (APS)** about each individual case.
- Do **not** say they need a guardian. Instead, you want to present the problem, not a solution to APS. Explain clearly how the individual is at risk, and what will happen if the worst case scenario takes place. **For example, loss of services.**

Be very articulate how the individual is vulnerable

Example:

- A person is on Medicaid and Home and Community Based Services (HCBS).
- The person does not have anyone listed as a representative (no family, no legal guardian, etc.) so may lose those services, which are vital to their well-being, because there is no one to work with the Clearinghouse or KDHE to receive and/or fill out renewal forms, answer questions, etc.
- If Medicaid and/or their HCBS services are lost, the person will not have access to necessary medications, assistance at home for daily living or may even become homeless.
- The APS **may** make a referral to the KS Guardianship Program, and the court will appoint a guardian for the individual. If they don't make a referral, call the issue in again and again until they do make a referral.

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Page 15 - Signature Page

K. Signature Page
 You must sign and date this form before you send it back. If this form is not signed, it will be returned to you. This will cause a delay in processing your application. Read the information below. Sign and Date.

I understand:

- I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.
- I have the right to have information I have provided kept confidential unless directly related to the administration of Kansas medical assistance programs.
- I have to provide an ID# for a Social Security Number for anyone who is applying for health benefits and authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the Social Security Administration, and Health Renewal Service.
- It is important to provide current income, address, and household composition information, and I am responsible for reporting changes during the application process and while eligible.
- I am or all of the people for whom I am applying may receive similar health coverage under the Medicaid program if eligible.
- I have the responsibility to use any existing resources (such as health insurance, long-term care, medical support payments, trusts, conservatorships, etc.) that may have a legal obligation to pay any or all of the medical expense of those for whom I am applying. I understand that agreement to a particular service may be withheld while a determination of eligibility to use a temporary 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 bill for those programs and any pay for services not covered by that third-party resource. I agree to cooperate with the medical assignment unit in pursuing those third-party resources.
- If I receive medical assistance after age 65 or while in an institutional arrangement, there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institution(s) will be notified of a pending claim.
- I have the responsibility to read and carefully answer all the questions on this application. I understand that if I provide false or knowingly 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 request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household are determined eligible for medical assistance.
- To help Child Support Services (CSS) in establishing and enforcing support orders if needed if adults in the household are determined eligible for medical assistance.
- To pay the Working Healthy premium each month if I qualify for that program. The premium may be as little as \$0 or as much as \$25 depending on my income.

I certify:

- That everyone I am requesting health coverage for - and who is determined eligible for such coverage - is a U.S. citizen or a lawful U.S. citizen in lawful immigration status. Proof of immigration status may be required. (Exception: persons applying for emergency medical assistance under EMOA).
- 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 physicians and other medical providers, or managed care organizations for covered medical and other health services furnished to those for whom I am applying who are eligible.
- Medical providers to release medical information to the Kansas Department of Health and Environment, Division of Health Care Finance (KDHC, DCHFC), the Department for Children and Families (DCF), the Kansas Department for Aging and Disability Services (KADS), the U.S. Department of Health and Human Services, insurance companies, and other contracted medical providers. I also authorize KDHC, DCF, and KADS to share medical information for administrative purposes with other agencies and contractors.
- Employers, medical providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances, to release to KDHC, DCF, KADS, or other benefit programs, any information including financial and other confidential information necessary to establish my eligibility.

No signature on this application signifies that I have read and understand the conditions above. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from this date. A copy of this authorization is as valid as the original.

Signature of Applicant (required) _____ Date _____

Signature of Other Adult Applying _____ Date _____

Signature of First Witness (if "X" is used) _____ Date _____

Signature of Second Witness (if "X" is used) _____ Date _____

Signature of Medical Representative (if applicable) _____ Date _____

FOR AGENCY USE ONLY

Would you like to register to vote today?
 No _____ Yes _____ Already registered _____

For how long is this application valid? (circle one) 3-60/90/180

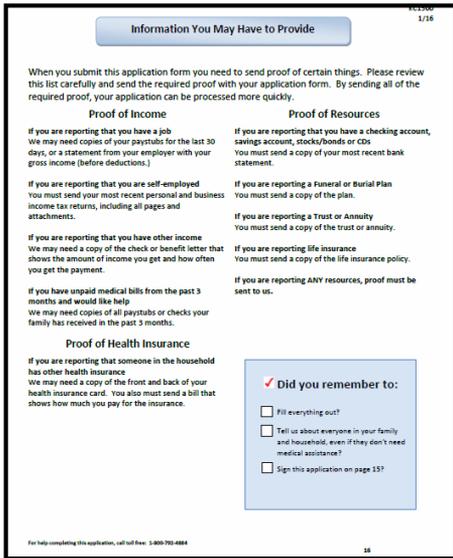
Signature of Applicant (required)	Date
Signature of Other Adult Applying	Date
Signature of First Witness (if "X" is used)	Date
Signature of Second Witness (if "X" is used)	Date
Signature of Medical Representative (if applicable)	Date

- It is important that the applicant and/or the guardian, and/or the conservator to sign this page.
- If KanCare receives the application unsigned, it will be considered incomplete.

Page 15

It is also important to **read the fine print** as it provides important information such as: estate recovery and consumer's rights and responsibilities.

Page 16



- That last page of the application is a checklist that provides you with reminders of what you need to send in with the application to speed up processing time.
- This checklist is much less detailed than the [Documentation Checklist](#) mentioned earlier in this lesson.
- Also, remember to watch out for further requests for documentation that may be needed to process your application fully.

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Help ensure success by contacting the Clearinghouse when you submit new documentation to confirm everything you sent was received.

Don't wait 3 months to contact them, only to find out they never received your documentation!

The KanCare Ombudsman office recommends that you follow up within a few days of sending new, important information.

Note to Nursing Facilities, Page 16

The screenshot shows a form titled "Information You May Have to Provide" with a sub-header "11-1500 1/16". The form contains the following sections:

- Information You May Have to Provide**
When you submit this application form you need to send proof of certain things. Please review this list carefully and send the required proof with your application form. By sending all of the required proof, your application can be processed more quickly.
- Proof of Income**
 - If you are reporting that you have a job: We may need copies of your paystubs for the last 30 days, or a statement from your employer with your gross income (before deductions.)
 - If you are reporting that you are self-employed: You must send your most recent personal and business income tax returns, including all pages and attachments.
 - If you are reporting that you have other income: We may need a copy of the check or benefit letter that shows the amount of income you get and how often you get the payment.
 - If you have unpaid medical bills from the past 3 months and would like help: We may need copies of all paystubs or checks your family has received in the past 3 months.
- Proof of Resources**
 - If you are reporting that you have a checking account, savings account, stocks/bonds or CDs: You must send a copy of your most recent bank statement.
 - If you are reporting a Funeral or Burial Plan: You must send a copy of the plan.
 - If you are reporting a Trust or Annuity: You must send a copy of the trust or annuity.
 - If you are reporting life insurance: You must send a copy of the life insurance policy.
 - If you are reporting ANY resources, proof must be sent to us.
- Proof of Health Insurance**
 - If you are reporting that someone in the household has other health insurance: We may need a copy of the front and back of your health insurance card. You also must send a bill that shows how much you pay for the insurance.

At the bottom of the form, there is a section titled "Did you remember to:" with three checkboxes:

- Fill everything out?
- Tell us about everyone in your family and household, even if they don't need medical assistance?
- Sign this application on page 15?

At the bottom left of the form, it says "3/3" and "For help completing this application, call toll free: 1-800-702-4884". At the bottom right, it says "16".

Be sure to submit both of the following with the application to avoid processing delays:

1. 2126 form
2. CARE Score

2126 form: This form tells KDHE when a person moves into a facility or moves out. It is not something that a consumer fills out or is responsible for. **The nursing facility needs to submit this form with the application.**

A CARE Score: This is part of the Level of CARE assessment that is completed by the ADRC when the individual is admitted to the nursing facility. **It is imperative that the nursing facility ensure that the CARE assessment is sent to KDADS to avoid processing delays and ensure the facility is paid for all dates the individual is a resident there.**

Printable Applications

Consumers

Choosing a Plan

Apply for KanCare

Benefits & Services

Events

FAQs

- Visit the KanCare website at www.kancare.ks.gov.
- Find the [PDF for each application packet](#).



URL for Printable Applications: <http://www.kancare.ks.gov/consumers/apply-for-kancare>

Medicaid-Related Resources



- From the Ombudsman’s section of the KanCare website
- Go to the [Resources](#) page

Resources page URL:

<https://www.kancare.ks.gov/kancare-ombudsman-office/resources>



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Resources page URL: <https://www.kancare.ks.gov/kancare-ombudsman-office/resources>

KanCare Ombudsman Resources

Forms

1. **Authorization for Release of Protected Health Information:** for an individual to get release of information for organizations, providers, or a class of persons (like a targeted case manager or care coordinator). The person or organization listed on line 1 and/or line 2 does not act on behalf of the member. The person or organization listed on line 1 and/or line 2 cannot request services for the beneficiary. [English](#) [Spanish](#) [Example Release of Information Form](#)
2. **Medical Representative Authorization:** for persons on Medicaid to authorize (allow) another person to help them with medical calls, paperwork, turn in your renewal each year, use your medical card for you, etc. If the person assisting is a DPOA or Guardian, they do not need to complete the Medical Representative form in order to act on behalf of the individual. The Financial DPOA paperwork or Guardianship paperwork must be provided to the KanCare Clearinghouse.
3. **Facilitator Form:** A facilitator is a person who can help fill out an application and help with the application process. Eligibility people will be able to share information with this person. This person will get copies of letters sent to the applicant about the application. After the application is processed, the facilitator is not connected to your case. A facilitator can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.
4. **Authorized Representative Designation Form for Grievances, Appeals and Fair Hearings**
[Authorized Representative Designation Form for Grievances, Appeals and Fair Hearings Large Print](#)
5. **Submitting a Change to KanCare Clearinghouse:** The member or their representative is responsible for reporting changes to income, address, phone and household composition while eligible.

General Information Fact Sheets

File	Type	Size	Uploaded on	Download
ADA and Deaf-HH	PDF	444.99 KB	09 May, 2018	Download
ADA and Deaf-HH -- Large Print	PDF	356.43 KB	09 May, 2018	Download
Adult Disabled Child	PDF	198.00 KB	09 May, 2018	Download
Adult Disabled Child -- Large Print	PDF	199.41 KB	09 May, 2018	Download
Early Detection Works	PDF	351.02 KB	09 May, 2018	Download
Early Detection Works -- Large Print	PDF	353.96 KB	09 May, 2018	Download
MediKan	PDF	306.00 KB	09 May, 2018	Download
MediKan -- Large Print	PDF	309.80 KB	09 May, 2018	Download
MSP Extra Help	PDF	265.21 KB	09 May, 2018	Download
MSP Extra Help -- Large Print	PDF	268.03 KB	09 May, 2018	Download
Refugee - Immigration	PDF	130.38 KB	09 May, 2018	Download
Refugee - Immigration -- Large Print	PDF	135.50 KB	09 May, 2018	Download
Selecting-Changing an MCO	PDF	297.43 KB	09 May, 2018	Download
Selecting-Changing an MCO -- Large Print	PDF	301.63 KB	09 May, 2018	Download

Additional Resources

1. [Understanding Long Term Care](#) Thank you to Prescott Country View, Prescott, KS for sharing this valuable document
2. [KanCare Clearinghouse Voicemail Menu](#)
3. [FAQ Good Cause Reasons to Change Your Plan](#)
4. [Consumer Access Guide to HCBS Services in Kansas](#)
5. [How to Apply for Medicare](#)
6. [Summary of HCBS Services Provided in Kansas](#)

Forms

1. **Authorization for Release of Protected Health Information:** for an individual to get release of information for organizations, providers, or a class of persons (like a targeted case manager or care coordinator)
[English](#)
[Spanish](#)
2. **Medical Representative Authorization:** for persons on Medicaid to authorize (allow) another person to help them with medical calls, paperwork, etc. If the person assisting is a DPOA or Guardian, they must include that paperwork with this form. Read the form carefully for details.
3. **Authorized Representative Designation Form:** for Appeals, Hearings and Grievances
4. **Submitting a Change to KanCare Clearinghouse**
5. **Third Party Liability Insurance Update**

Ongoing Education

Quick Links

- About Us
- Resources
- Grievance, Appeals and Fair Hearings
- KanCare FAQ's
- KanCare General Information Fact Sheets
- Home and Community Based Services Fact Sheets
- **Community Training**
- Volunteer Program

• On the KanCare Ombudsman website: www.kancareombudsman.ks.gov

• Look for the [Community Training](#) link in the dropdown menu.

➤ Videos

➤ In-Person Training

URL: <https://www.kancare.ks.gov/kancare-ombudsman-office/liaison-training>



Check out our on-line **Ongoing Education** for more in-depth training on a variety of Medicaid related topics.

URL: <http://www.kancare.ks.gov/kancare-ombudsman-office/volunteer-program/ongoing-education>

The KanCare Ombudsman is Here to Assist You



Toll Free: **1-855-643-8180**

KanCare.Ombudsman@ks.gov

