A Guide to Completing the KC-1500 Application Sections I & J

A Guide to Completing the KC-1500 Application

For the Elderly and Persons with Disabilities

KanCare

Sections I & J

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

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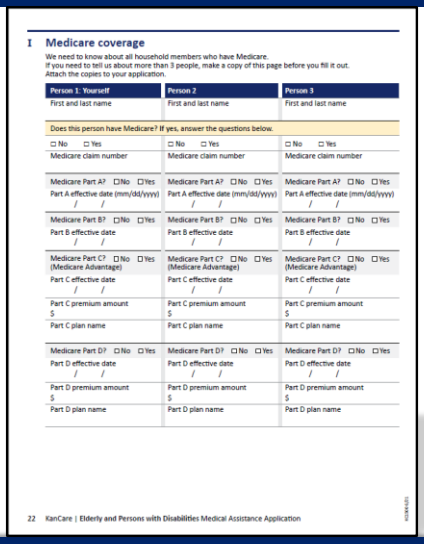
Welcome to the guide for Sections I & J of the KanCare Application Guide. Next, we will cover page 22 through the middle of page 24.

Page 22: KC-1500: Medicare Coverage

Pg. 22



I **Medicare coverage**

We need to know about all household members who have Medicare.
If you need to tell us about more than 3 people, make a copy of this page before you fill it out.
Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First and last name	First and last name	First and last name
Does this person have Medicare? If yes, answer the questions below.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medicare claim number	Medicare claim number	Medicare claim number
Medicare Part A? ☐ No ☐ Yes	Medicare Part A? ☐ No ☐ Yes	Medicare Part A? ☐ No ☐ Yes
Part A effective date (mm/dd/yyyy) / /	Part A effective date (mm/dd/yyyy) / /	Part A effective date (mm/dd/yyyy) / /
Medicare Part B? ☐ No ☐ Yes	Medicare Part B? ☐ No ☐ Yes	Medicare Part B? ☐ No ☐ Yes
Part B effective date / /	Part B effective date / /	Part B effective date / /
Medicare Part C? ☐ No ☐ Yes (Medicare Advantage)	Medicare Part C? ☐ No ☐ Yes (Medicare Advantage)	Medicare Part C? ☐ No ☐ Yes (Medicare Advantage)
Part C effective date / /	Part C effective date / /	Part C effective date / /
Part C premium amount $	Part C premium amount $	Part C premium amount $
Part C plan name	Part C plan name	Part C plan name
Medicare Part D? ☐ No ☐ Yes	Medicare Part D? ☐ No ☐ Yes	Medicare Part D? ☐ No ☐ Yes
Part D effective date / /	Part D effective date / /	Part D effective date / /
Part D premium amount $	Part D premium amount $	Part D premium amount $
Part D plan name	Part D plan name	Part D plan name

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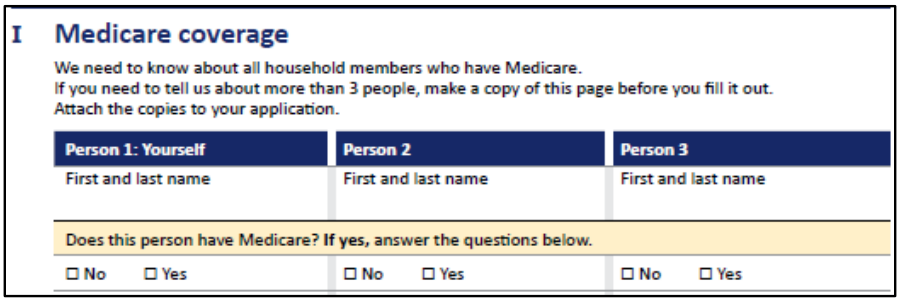
This is page 22 of the paper application for the Elderly and Persons with Disabilities. We need to know about all household members who have Medicare. If the applicant needs to tell us about more than 3 people, they can make a copy of this page before filling it out. Attach the copies to the application.

Next, we will go through each part of the twenty-second page, or section I.

Medicare Coverage

Pg. 22



I **Medicare coverage**

We need to know about all household members who have Medicare.
If you need to tell us about more than 3 people, make a copy of this page before you fill it out.
Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First and last name	First and last name	First and last name
Does this person have Medicare? **If yes,** answer the questions below.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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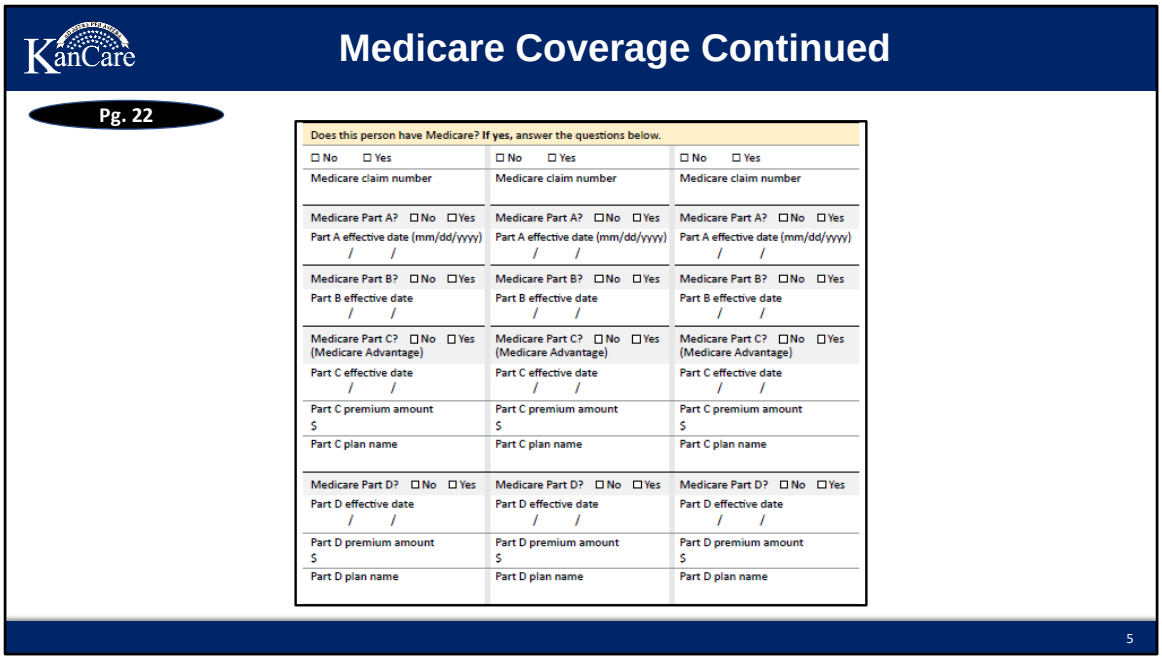
The first question on page 22 asks, “Does this person have Medicare?” The applicant must check “No” or “Yes”.

If the applicant checks “Yes” they will need to fill out the following questions about Medicare coverage. If a person on the application checks “No” then the rest of the Medicare details will not need to be filled out.

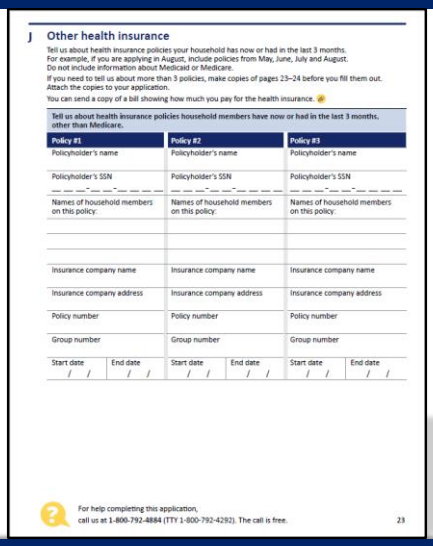


If “Yes” has been checked under the primary applicant column or Person 2 and 3 then the following questions about Medicare should be answered to the best of their ability. If the applicant is unable to find the information needed, such as the effective date, it is okay to leave it blank.

Each “No” and “Yes” box should be checked if someone says they have Medicare coverage.

Page 23: KC-1500: Other Health Insurance

Pg. 23



J Other health insurance

Tell us about health insurance policies your household has now or had in the last 3 months.
For example, if you are applying in August, include policies from May, June, July and August.
Do not include information about Medicaid or Medicare.
If you need to tell us about more than 3 policies, make copies of pages 23–24 before you fill them out.
Attach the copies to your application.
You can send a copy of a bill showing how much you pay for the health insurance.

Tell us about health insurance policies household members have now or had in the last 3 months, other than Medicare.

Policy #1	Policy #2	Policy #3
Policyholder's name	Policyholder's name	Policyholder's name
Policyholder's SSN	Policyholder's SSN	Policyholder's SSN
Names of household members on this policy:	Names of household members on this policy:	Names of household members on this policy:
Insurance company name	Insurance company name	Insurance company name
Insurance company address	Insurance company address	Insurance company address
Policy number	Policy number	Policy number
Group number	Group number	Group number
Start date / / / End date / /	Start date / / / End date / /	Start date / / / End date / /

For help completing this application, call us at 1-800-792-4884 (TTY 1-800-792-4292). The call is free. 23

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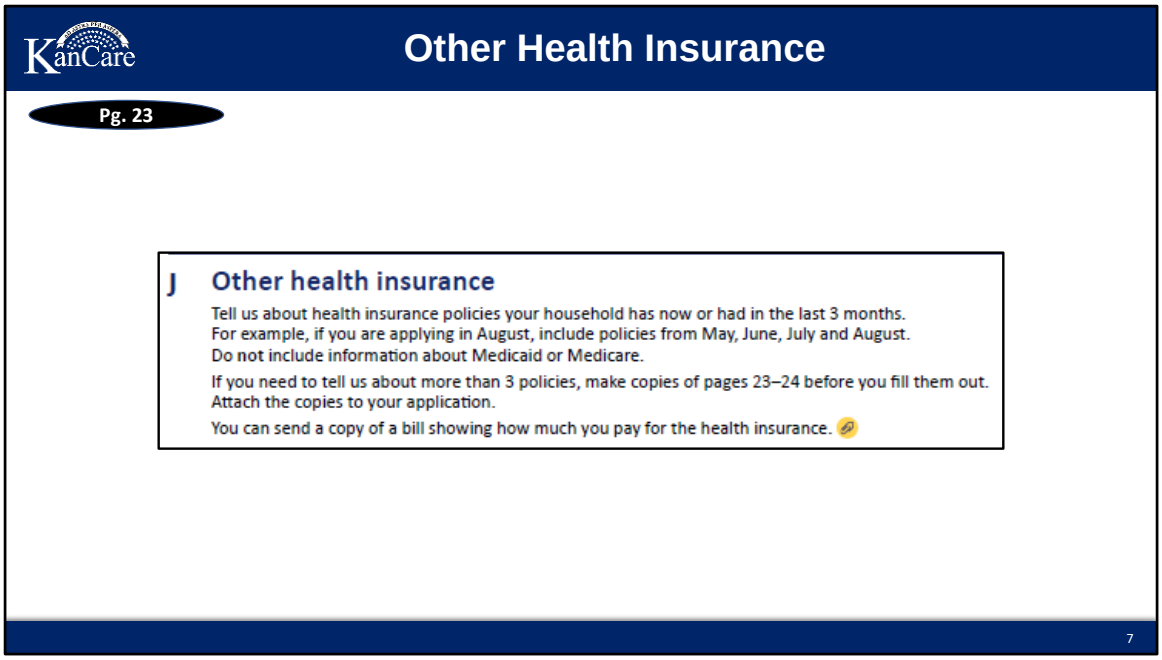
This is page 23 of the paper application for the Elderly and Persons with Disabilities.

You will see that on this page there is a paper clip icon. Remember that the paperclip icon means we may ask for proof later or the applicant can send it now. See the list on page 31 for more information.

Next, we will go through each part of the twenty-third page, or section J.

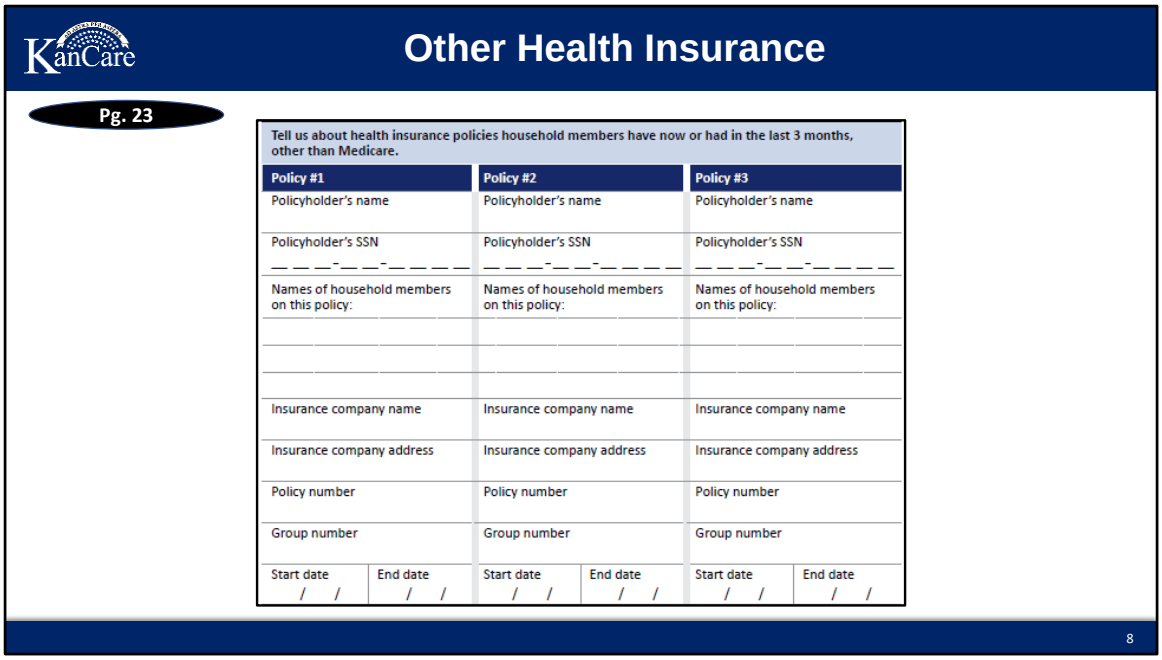


Page 23 asks about other health insurance. Here the applicant will put information about health insurance policies their household has now or had in the last 3 months. For example, if someone is applying in August, they should include policies from May, June, July and August. This section is not asking for information about Medicaid or Medicare.

This may include Medicare supplemental insurance policies, health insurance through an employer, or long term care insurance.

If more room is needed, make copies of pages 23-24 before filling them out. Attach the copies to the application.

The applicant can send a copy of a bill showing how much is paid for the health insurance.



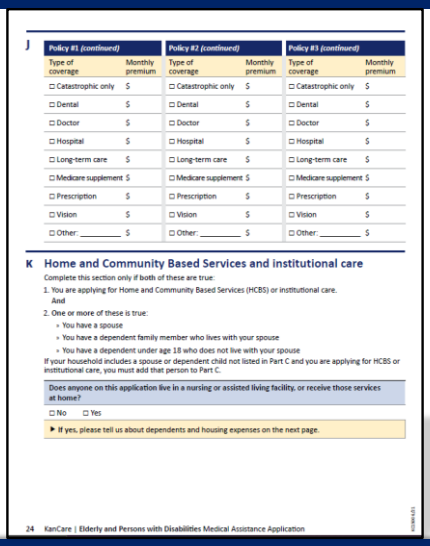
If any household member on the application currently has or had health insurance policies in the last three months other than Medicare they will put that information here.

For each policy the applicant will put the policyholder's name, the policyholder's social security number, names of household members on the policy, the insurance company name, the insurance company address, the policy number, the group number, and lastly, the start and end date of the policy.

If information about other health insurance is unknown it is okay to leave portions blank, we may be able to verify other health insurance.

Page 24: KC-1500: Other Health Insurance (con't)

Pg. 24



J

Policy #1 (continued)		Policy #2 (continued)		Policy #3 (continued)	
Type of coverage	Monthly premium	Type of coverage	Monthly premium	Type of coverage	Monthly premium
☐ Catastrophic only	$	☐ Catastrophic only	$	☐ Catastrophic only	$
☐ Dental	$	☐ Dental	$	☐ Dental	$
☐ Doctor	$	☐ Doctor	$	☐ Doctor	$
☐ Hospital	$	☐ Hospital	$	☐ Hospital	$
☐ Long-term care	$	☐ Long-term care	$	☐ Long-term care	$
☐ Medicare supplement	$	☐ Medicare supplement	$	☐ Medicare supplement	$
☐ Prescription	$	☐ Prescription	$	☐ Prescription	$
☐ Vision	$	☐ Vision	$	☐ Vision	$
☐ Other: _____	$	☐ Other: _____	$	☐ Other: _____	$

K Home and Community Based Services and institutional care

Complete this section only if both of these are true:

1. You are applying for Home and Community Based Services (HCBS) or institutional care.
   And
2. One or more of these is true:
   - You have a spouse
   - You have a dependent family member who lives with your spouse
   - You have a dependent under age 18 who does not live with your spouse

If your household includes a spouse or dependent child not listed in Part C and you are applying for HCBS or institutional care, you must add that person to Part C.

Does anyone on this application live in a nursing or assisted living facility, or receive those services at home?

☐ No ☐ Yes

▶ If yes, please tell us about dependents and housing expenses on the next page.

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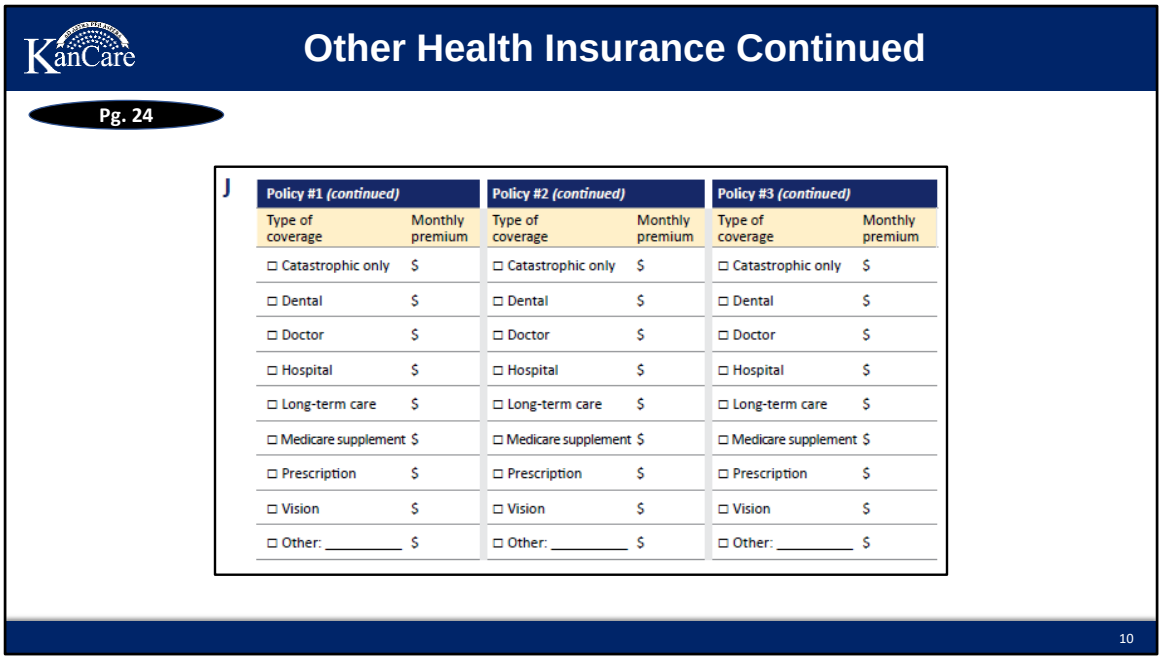
This is page 24 of the paper application for the Elderly and Persons with Disabilities. In this guide we will focus on the top half which is the last portion of section J.

Next, we will go through the rest of section J.



The information here is still regarding other health insurance in the household. If the applicant has filled out policy information on page 23 then they should check the boxes for each type of coverage the policy or policies have and the monthly premium amount.

Premium amounts the applicant pays for other health insurance may help lower their share of cost for certain programs. We may need proof of the premium and may ask for it if it was not provided at the time the KanCare application is submitted.

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Thank you for looking at this guide for the KanCare Application for the Elderly and Persons with Disabilities Medical Assistance Application.