Families with Children
Medical Assistance Application

Apply faster online! Go to ApplyforKanCare.ks.gov.

This application is for families, children without disabilities, and pregnant women.
If you are applying for a child or adult with a disability or for someone who is elderly, use the ***Elderly and Persons with Disabilities*** *Medical Assistance Application*.

Make sure you:

1. **Answer** all questions on the application
2. **Sign** the application on page 30
3. **Include** any proof you want to send. You do not have to send any proof now. See page 31 for a list of proof we may need if we cannot obtain it on our own.
4. **Mail** your completed and signed application to:

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

   Or Fax to: 1-800-498-1255

Contents

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

By law, we must keep your information private. We will use your application information only to see if you qualify for medical assistance.

We have free interpreters if you need help in other languages.

العربية / ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافرلك بالمجان. اتصل برقم 1-800-792-4884 (رقم هاتف الصم والبكم: 1-800-792-4292).

မွန်မာ / BURMESE

သတိပြုရန် - အ ယ်၍ သင်သည် မြန်မာစ ား ို ပြောပါ ၊ ဘာသာစ ား အ ူအညီ၊ အခမဲ့၊ သင့်အတွ ် စီစဉ်ဆောင်ရွ ်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-792-4884** (TTY: **1-800-792-4292**) သို့ ခေါ်ဆိုပါ။

中文 / CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-792-4884 (**TTY: **1-800-792-4292)**。

فارسی / FARSI

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-792-4884 (TTY: 1-800-792-4292) تماس بگیرید.

FRANÇAIS / FRENCH

Attention: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-792-4884** (ATS : **1-800-792-4292).**

DEUTSCHE / GERMAN

Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-792-4884** (TTY: **1-800-792-4292**).

HMOOB / HMONG

Lus Ceev: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-792-4884** (TTY: **1-800-792-4292**).

日本語 / JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-792-4884** (TTY: **1-800-792-4292**) まで、お電話にてご連絡ください。

한국어 / KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-792-4884** (TTY: **1-800-792-4292**) 번으로 전화해 주십시오.

한국어 / LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽ້ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-792-4884** (TTY: **1-800-792-4292**).

РУССКИЙ / RUSSIAN

Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-792-4884** (телетайп: **1-800-792-4292**).

ESPAÑOL / SPANISH

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-792-4884** (TTY: **1-800-792-4292**).

SWAHILI

Kumbuka: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu **1-800-792-4884** (TTY: **1-800-792-4292**).

TAGALOG

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-792-4884** (TTY: **1-800-792-4292**).

TIẾNG VIỆT / VIETNAMESE

Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-792-4884** (TTY: **1-800-792-4292**).

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For adults who need coverage:

Include these people *even if they aren't applying for health coverage themselves:*

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return, including any children over age 21 who are claimed on a parent's tax return. You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:

Include these people *even if they aren't applying for health coverage themselves:*

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

The paper clip means we may ask for proof later. Or you can send it now. See the list on page 31.

A Tell us about the primary applicant

The primary applicant is the person who needs medical assistance. If the person who needs medical assistance is a child, then the primary applicant is the child's parent or the head of household. Where you see "Yourself" and "You" that also means the primary applicant.

Primary applicant: Yourself *(or the parent or head of household if the person applying is a child)*

Your name

First name	Middle name	Last name

Other names used (such as maiden name)

Your contact information

Home address		**Mailing** address (if different from **Home** address)	
City	State	City	State
County	ZIP Code	County	ZIP Code

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

Home phone	Work phone
___ ___ ___–___ ___ ___–___ ___ ___ ___	___ ___ ___–___ ___ ___–___ ___ ___ ___

▶ May we contact you by:	☐ Email	Email address:
	☐ Text	Cell phone number: ___ ___ ___–___ ___ ___–___ ___ ___ ___

What language do you **speak** at home?	What language do you **read and write** at home?

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

B Tell us about yourself and the people in your household

- Start with yourself (the primary applicant, or the parent or head of household if the person applying is a child).
- There is room on this application for 6 people. Pages 4–10 are for Persons 1, 2, 3. Pages 11–17 are for Persons 4, 5, 6.
- If more than 6 people are in your household, make copies of **pages 11–17** before you fill them out.

Use the copies to complete persons 7, 8, 9 and so on. Attach the copies to your application.

1: Yourself	Person 2	Person 3
Each person's name		
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
Is this person applying for medical assistance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is each person's relationship to you?		
Person 1 is my: ***Self***	Person 2 is my:	Person 3 is my:
Gender		
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)		
/ /	/ /	/ /
Marital status		
☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)
Does this person live at the same address as Person 1?		
Leave blank	☐ No ☐ Yes	☐ No ☐ Yes
	▶ **If no,** list address:	▶ **If no,** list address:

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B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 ***(continued)***	**Person 2** ***(continued)***	**Person 3** ***(continued)***
First and last name	First and last name	First and last name
In the past year did this person (check all that apply):		
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these
Is this person under 26?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** were they in foster care at the time of their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person under 23? **If yes,** answer the next 2 questions.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Are they a full-time student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Have they had insurance through a job **and** lost it within the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what was the end date and reason?		
End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /
Reason	Reason	Reason

We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. We use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are **not** applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. If you don't give your SSN, you can still apply.

What is this person's Social Security Number?		
Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __

B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Is this person a U.S. citizen or U.S. national? **Must** answer if applying for medical assistance.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us this person's alien number and certificate number.		
Alien number (optional)	Alien number (optional)	Alien number (optional)
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
If this person is **not** a U.S. citizen or U.S. national, do they have eligible immigration status?		
☐ Yes	☐ Yes	☐ Yes
▶ **If yes,** tell us more about this person's immigration status.		
Document type	Document type	Document type
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
Card number or passport number	Card number or passport number	Card number or passport number
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
Other (category code or country where issued)	Other (category code or country where issued)	Other (category code or country where issued)
Has this person lived in the U.S. since 1996?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person, or is their spouse or parent, a veteran or an active duty member of the U.S. military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 *(continued)*	**Person 2** *(continued)*	**Person 3** *(continued)*
First and last name	First and last name	First and last name
What is this person's **race**? Check all that apply. *This question is optional. You do not have to answer.*		
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other
What is this person's **ethnicity**? If Hispanic or Latino ethnicity, check all that apply. *This question is optional. You do not have to answer.*		
☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other
Does anyone in your household have discharged, forgiven or canceled student loan debt after January 1, 2018?		
☐ No ☐ Yes **If yes,** complete the following.		
What year was it discharged, forgiven or canceled?		
How much was discharged, forgiven or canceled?		
$	$	$
Was it discharged, forgiven or canceled because of the permanent disability or death of the student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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

B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 *(continued)*	**Person 2** *(continued)*	**Person 3** *(continued)*
First and last name	First and last name	First and last name
Is this person pregnant?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how many babies are expected?		
▶ **If yes,** what is the expected due date? Estimate if unknown. (mm/dd/yyyy) *This question is optional. You do not have to answer.*		
/ /	/ /	/ /
Answer the next 5 questions **only** for persons applying for assistance. For any person not applying, go to "Section D: Federal income tax information" on **page 10**.		
If this person is applying, do they have a disability that will last at least 12 months or result in death?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying for in-home care or nursing home costs?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they incarcerated (in jail or detained)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** are they facing disposition of charges (waiting for the final outcome of an arrest or prosecution)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they live with, and are they the main person taking care of, at least one child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they a child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** please tell us the names of the child's parents:		
Parent 1 First, middle, and last name	Parent 1 First, middle, and last name	Parent 1 First, middle, and last name
Parent 2 First, middle, and last name	Parent 2 First, middle, and last name	Parent 2 First, middle, and last name

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c Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July.

Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for Yourself, Person 2, and Person 3.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Answer the next 4 questions **only** for persons applying for assistance. For any person not applying, go to "Section D: Federal income tax information" on page 10.		
If this person is applying, did they deliver a baby in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, did they have emergency care in the last 3 months to save life, organs or bodily function?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying medical bills from the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, have they lived in a state other than Kansas in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

D Federal income tax information

Tell us how you and your household plan to file your taxes.
Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 ***(continued)***	**Person 2** ***(continued)***	**Person 3** ***(continued)***
First and last name	First and last name	First and last name
Based on their current situation, does this person plan to file a federal income tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** will this person file jointly with a spouse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse	**If yes,** name of spouse	**If yes,** name of spouse
▶ **If yes,** does this person have any dependents on their tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list names of dependents	**If yes,** list names of dependents	**If yes,** list names of dependents
Is this person claimed as a dependent on the tax return of someone who is **not** a household member?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, who **claims** Person 1 as a dependent on their tax return?	**If yes,** who **claims** Person 2 as a dependent on their tax return?	**If yes,** who **claims** Person 3 as a dependent on their tax return?
How is Person 1 related to the person who **claims** them? *For example, Person 1 is the **child** of the person who claims them.*	How is Person 2 related to the person who **claims** them? *For example, Person 2 is the **child** of the person who claims them.*	How is Person 3 related to the person who **claims** them? *For example, Person 3 is the **child** of the person who claims them.*

If you don't have more than 3 people in your household, go to "Section E: Tell us about changes in your household" on **page 18**.

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B Tell us about Persons 4, 5, and 6

Please answer questions about Person 4, Person 5, and Person 6 in your household. If you don't have more than 3 people in your household, go to "Section E: Tell us about changes in your household" on **page 18**.

Person 4	Person 5	Person 6
Each person's name		
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
Is this person applying for medical assistance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is each person's relationship to you?		
Person 4 is my:	Person 5 is my:	Person 6 is my:
Gender		
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)		
/ /	/ /	/ /
Marital status		
☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)
Does this person live at the same address as Person 1?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If no,** list address:	▶ **If no,** list address:	▶ **If no,** list address:

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

B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
In the past year did this person (check all that apply):		
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these
Is this person under 26?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** were they in foster care at the time of their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person under 23? **If yes,** answer the next 2 questions.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Are they a full-time student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Have they had insurance through a job **and** lost it within the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what was the end date and reason?		
End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /
Reason	Reason	Reason

We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. We use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are **not** applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. If you don't give your SSN, you can still apply.

What is this person's Social Security Number?		
Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __

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B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5 *(continued)***	**Person 6 *(continued)***
First and last name	First and last name	First and last name
Is this person a U.S. citizen or U.S. national? **Must** answer if applying for medical assistance.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us this person's alien number and certificate number.		
Alien number (optional)	Alien number (optional)	Alien number (optional)
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
If this person is **not** a U.S. citizen or U.S. national, do they have eligible immigration status?		
☐ Yes	☐ Yes	☐ Yes
▶ **If yes,** tell us more about this person's immigration status.		
Document type	Document type	Document type
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
Card number or passport number	Card number or passport number	Card number or passport number
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
Other (category code or county where issued)	Other (category code or county where issued)	Other (category code or county where issued)
Has this person lived in the U.S. since 1996?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person, or is their spouse or parent, a veteran or an active duty member of the U.S. military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5 *(continued)***	**Person 6 *(continued)***
First and last name	First and last name	First and last name
What is this person's **race**? Check all that apply. *This question is optional. You do not have to answer.*		
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other
What is this person's **ethnicity**? If Hispanic or Latino ethnicity, check all that apply. *This question is optional. You do not have to answer.*		
☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other
Does anyone in your household have discharged, forgiven or canceled student loan debt after January 1, 2018?		
☐ No ☐ Yes **If yes,** complete the following.		
What year was it discharged, forgiven or canceled?		
How much was discharged, forgiven or canceled?		
$	$	$
Was it discharged, forgiven or canceled because of the permanent disability or death of the student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
Is this person pregnant?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how many babies are expected?		
▶ **If yes,** what is the expected due date? Estimate if unknown. (mm/dd/yyyy) *This question is optional. You do not have to answer.*		
/ /	/ /	/ /
Answer the next 5 questions **only** for persons applying for assistance. For any person not applying, go to "D: Federal income tax information" on **page 17**.		
If this person is applying, do they have a disability that will last at least 12 months or result in death?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying for in-home care or nursing home costs?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they incarcerated (in jail or detained)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** are they facing disposition of charges (waiting for the final outcome of an arrest or prosecution)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they live with, and are they the main person taking care of, at least one child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they a child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** please tell us the names of the child's parents:		
Parent 1 First, middle, and last name	Parent 1 First, middle, and last name	Parent 1 First, middle, and last name
Parent 2 First, middle, and last name	Parent 2 First, middle, and last name	Parent 2 First, middle, and last name

c Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July.

Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
Answer the next 4 questions **only** for persons applying for assistance. For any person not applying, go to "Section D: Federal income tax information" on **page 17**.		
If this person is applying, did they deliver a baby in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, did they have emergency care in the last 3 months to save life, organs or bodily function?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying medical bills from the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, have they lived in a state other than Kansas in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

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D Federal income tax information

Tell us how you and your household plan to file your taxes.
Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
Based on their current situation, does this person plan to file a federal income tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** will this person file jointly with a spouse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse	**If yes,** name of spouse	**If yes,** name of spouse
▶ **If yes,** does this person have any dependents on their tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list names of dependents	**If yes,** list names of dependents	**If yes,** list names of dependents
Is this person claimed as a dependent on the tax return of someone who is **not** a household member?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, who **claims** Person 4 as a dependent on their tax return?	**If yes,** who **claims** Person 5 as a dependent on their tax return?	**If yes,** who **claims** Person 6 as a dependent on their tax return?
How is Person 4 related to the person who **claims** them? *For example, Person 4 is the **child** of the person who claims them.*	How is Person 5 related to the person who **claims** them? *For example, Person 5 is the **child** of the person who claims them.*	How is Person 6 related to the person who **claims** them? *For example, Person 6 is the **child** of the person who claims them.*

E Tell us about changes in your household

Has your household **size** changed in the last 3 months because someone moved in or out?

☐ No ☐ Yes **If yes,** tell us about the **household** changes:

Has your household **income** changed in the last 3 months?

☐ No ☐ Yes **If yes,** tell us about the income changes:

F Tax deductions

Tell us about anything deducted on your federal income tax return, such as alimony, student loan interest, etc. This could help lower your cost for medical assistance. Do not include deductions related to self-employment. If you have more than 3 deductions, make a copy of this page before you fill it out. Attach the copy to your application.

Deduction #1	Deduction #2	Deduction #3
Name of person with deduction	Name of person with deduction	Name of person with deduction
Type of deduction	Type of deduction	Type of deduction
Amount $	Amount $	Amount $
How often?	How often?	How often?

G Jobs and other household income

If you need to tell us about more than 3 jobs in your household, make copies of **pages 18-19** before you fill them out. Attach the copies to your application.

Does anyone in your household have a job?

☐ No ☐ Yes **If yes,** tell us about **all** jobs of **all** household members.

Job #1	Job #2	Job #3
Worker's name	Worker's name	Worker's name
Company name	Company name	Company name
Company address	Company address	Company address
Company phone	Company phone	Company phone

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Job #1 *(continued)*	**Job #2** *(continued)*	**Job #3** *(continued)*
Worker's name	Worker's name	Worker's name
Income **before** any taxes or deductions are taken out:		
This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year	This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year	This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year
▶ What deductions are taken out of the gross pay before taxes? Check the box and tell us the amount:		
☐ Health Insurance (includes dental, vision, and accident) $	☐ Health Insurance (includes dental, vision, and accident) $	☐ Health Insurance (includes dental, vision, and accident) $
☐ Health Savings Accounts (HSAs) $	☐ Health Savings Accounts (HSAs) $	☐ Health Savings Accounts (HSAs) $
☐ Flexible Spending Accounts (FSAs) $	☐ Flexible Spending Accounts (FSAs) $	☐ Flexible Spending Accounts (FSAs) $
☐ Retirement Accounts (such as 401K or IRA) $	☐ Retirement Accounts (such as 401K or IRA) $	☐ Retirement Accounts (such as 401K or IRA) $
☐ Life Insurance $	☐ Life Insurance $	☐ Life Insurance $
☐ Other deduction: _____ $	☐ Other deduction: _____ $	☐ Other deduction: _____ $
Date of next paycheck (mm/dd/yyyy):		
/ /	/ /	/ /
How many hours does this person usually work each week?		
Regular hours / Overtime hours	Regular hours / Overtime hours	Regular hours / Overtime hours
▶ If this job pays hourly, what is the hourly rate?		
Regular rate $ /hr / Overtime rate $ /hr	Regular rate $ /hr / Overtime rate $ /hr	Regular rate $ /hr / Overtime rate $ /hr
Do any of these jobs include tips, commissions or bonuses?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what type? Check all that apply.		
☐ Tips ☐ Commissions ☐ Bonuses	☐ Tips ☐ Commissions ☐ Bonuses	☐ Tips ☐ Commissions ☐ Bonuses
▶ **If yes,** what is the usual amount before deductions?		
$	$	$
How often? ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Quarterly ☐ Twice a month ☐ Yearly	**How often?** ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Quarterly ☐ Twice a month ☐ Yearly	**How often?** ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Quarterly ☐ Twice a month ☐ Yearly

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

G

Is anyone in your household self-employed?

Self-employed means the 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.

☐ No ☐ Yes **If yes,** complete the following.

If you need to tell us about more than 3 self-employed jobs, make a copy of this page before you fill it out. Attach the copy to your application.

We may ask you to send your most recent personal and business income tax returns, including all pages and attachments.

Self-employed job #1	Self-employed job #2	Self-employed job #3
Name of self-employed person	Name of self-employed person	Name of self-employed person
Business name (if any)	Business name (if any)	Business name (if any)
What type of business is it?	What type of business is it?	What type of business is it?
What is the estimated monthly income this year?		
$	$	$
What are the estimated monthly expenses this year?		
$	$	$
Have the monthly income or expenses changed since you filed taxes last year?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** why have they changed?		

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G

Does anyone in your household have income from sources other than work?

☐ No ☐ Yes **If yes,** complete the following.

You are not required to tell us about some kinds of income such as SSI, veterans' payments, child support, tribal income obtained from natural resources, designated Indian trust land, or sales of items with cultural significance.

If you need to tell us about multiple household members receiving any of the income items below, make copies of this page before you fill it out. Attach the copy to your application.

Type or source of income	Name of person who receives this income	Amount	How often	Claim number, if any
Social Security benefits ☐ No ☐ Yes		$		
Trust or annuity payments ☐ No ☐ Yes		$		
Retirement or pension source: _____ ☐ No ☐ Yes		$		
Workers' compensation ☐ No ☐ Yes		$		
Unemployment ☐ No ☐ Yes		$		
Tribal payments ☐ No ☐ Yes		$		
Oil royalties or mineral rights ☐ No ☐ Yes		$		
Contract sale ☐ No ☐ Yes		$		
Rental income ☐ No ☐ Yes		$		
Spousal support from an agreement or agreement change dated December 31, 2018, or earlier ☐ No ☐ Yes		$		
Single payout lottery or gambling winnings of $80,000 or more after January 1, 2018. ☐ No ☐ Yes **If yes,** when: / /		$		
Other income source: _____ ☐ No ☐ Yes		$		

H 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. Also include policies for household members under age 19. If you do not know an answer, write "unknown."

If you need to tell us about more than 3 policies, make a copy of this page before you fill it out. Attach the copy to your application.

Tell us about health insurance policies household members have now or had in the last 3 months:

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 / /
If ended, why? (left job, too expensive, etc.)	If ended, why? (left job, too expensive, etc.)	If ended, why? (left job, too expensive, etc.)
Type of coverage	Type of coverage	Type of coverage
☐ Catastrophic only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long-term care ☐ Medicare supplement ☐ Prescription ☐ Vision ☐ Other: _____	☐ Catastrophic only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long-term care ☐ Medicare supplement ☐ Prescription ☐ Vision ☐ Other: _____	☐ Catastrophic only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long-term care ☐ Medicare supplement ☐ Prescription ☐ Vision ☐ Other: _____

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I Health coverage from jobs

Answer the questions on this page and the next page only if **both** of these statements are true for your household:

1. Someone in your household can get health coverage from a job.
   And
2. Your **gross** household income before taxes and deductions is **more** than the levels on the *Helpful Hints* flyer that came with this application.

Attach a copy of **pages 23-24** for each job that offers coverage. Tell us about the **job** that offers coverage.

Employee

Employee first and last name	Employee Social Security Number (SSN) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Employer

Employer name	Employer Identification Number (EIN)	
Employer address		
City	State	ZIP Code
Employer phone number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___		

Who can we contact about employee health coverage at this job?

First and last name	Phone number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___
	Email address

Do you qualify now or will you qualify in the next 3 months for coverage offered by this employer?

☐ No **If no,** stop here and go to Section J on **page 25**.
☐ Yes **If yes**, please answer the questions below.

▶ If you're in a waiting period or probationary period, when can you enroll in coverage?

Date you can enroll (mm/dd/yyyy): / /

List the names of any household members who qualify for coverage from this job:

First and last name	First and last name
First and last name	First and last name
First and last name	First and last name

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

I

Tell us about the health plan offered by the employer.

Does the employer offer a health plan that meets the minimum value standard? *See definition at right.*

☐ No ☐ Yes

Tell us about the premium (cost) for the **lowest** cost **individual** plan that is offered **only** to the employee and meets the **minimum value standard** (see box at right). Don't include family plans.

If the employer offers wellness programs, use the premium amount the employee would pay after the maximum discount for any **quit smoking** programs. Do not include discounts for other wellness programs.

Minimum value standard (MVS)

A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services.

Most job-based plans meet the minimum value standard.

How much would the employee pay for the employer-offered, lowest cost, individual, MVS plan?

Premium amount	How often?		
$	☐ Weekly	☐ Every 2 weeks	☐ Twice a month
	☐ Monthly	☐ Quarterly	☐ Yearly

What change will the employer make for the new plan year, if known?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest cost plan that is available **only** to the employee and meets the minimum value standard. Premium should reflect the discount for wellness programs. See above question.

☐ I don't know

▶ How much will the employee have to pay in premiums for this plan?

Premium amount	How often?			Date of change (mm/dd/yyyy):
$	☐ Weekly	☐ Every 2 weeks	☐ Twice a month	/ /
	☐ Monthly	☐ Quarterly	☐ Yearly	

J Parent living outside of the home

Does anyone on this application have a child under the age of 19 whose other parent lives outside the home?

☐ No ☐ Yes

▶ **If yes,** that person will be asked to cooperate with the agency that collects medical support from an absent parent.

If that person thinks that cooperating to collect medical support will bring harm to them or their children, they can tell KanCare and may not have to cooperate.

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K American Indian or Alaska Native

Complete this page if you or family members are American Indian or Alaska Native. If you need to tell us about more than 3 people, make copies of this page before you fill it out. Attach the copies to your application.

Tell us about your American Indian or Alaska Native family members.

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Service, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer these questions to make sure you and your family get the most help possible.

AI or AN Person 1	AI or AN Person 2	AI or AN Person 3
First and last name	First and last name	First and last name
Is this person a member of a federally recognized tribe?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what is the name of the tribe?		
Name of the tribe	Name of the tribe	Name of the tribe
Has this person ever gotten a service or a referral from the Indian Health Service, a tribal health program or an urban Indian health program?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If no,** does this person qualify for services or a referral from the Indian Health Service, a tribal health program or an urban Indian health program?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Certain money received may not be counted for Medicaid or CHIP. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, or leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) • Money from selling things that have cultural significance		
Amount of income $	Amount of income $	Amount of income $
How often?	How often?	How often?

L Choose a health plan

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

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

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

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

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

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

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

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M If you have someone to help you with your case

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

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

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

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

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

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

First and last name	Organization name (if any)

Address	City	State	ZIP Code

Phone number	Email address

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

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

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

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

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

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

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

First and last name

Address	City	State	ZIP Code

Phone number	Email address

N Read and sign

Before you send your application, you must sign and date it on **page 30**.

Please read the information below. Then **sign and date** in the spaces provided.

I understand:

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

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

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

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N Read and sign *(continued)*

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

I agree:

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

I certify:

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

I authorize:

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

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

N Read and sign *(continued)*

By signing this application, I state that:

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

Primary applicant must sign here — Date

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

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

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

Medical representative may sign here (if any) — Date

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List of proof

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

Proof of income

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

Proof of health insurance

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

Did you remember to:

1. **Answer all questions on the application?**

2. **Tell us about all household members even if they don't need medical assistance?**

3. **Include any proof you want to send now?**

4. **Sign the application on page 30?**

5. **Finally, mail or fax your completed and signed application to:**
KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738

Fax: 1-800-498-1255

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

☐ Yes ☐ No

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

then you can file a complaint by mail or phone:

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

By phone
1-800-262-8683

KanCare

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