Supplement

to the ***Families with Children*** *Medical Assistance Application*

This form is not a valid application by itself.

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

This form is for applicants who have already filled out the ***Families with Children*** *Medical Assistance Application,* but need help under our Medical Assistance Programs for ***Elderly and Persons with Disabilities.***

The paper clip means we may ask for proof later. Or you can send it now. See the list on page 12.

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
___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

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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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 3 people. If more than 3 people are in your household, make copies of **pages 3–7** before you fill them out. Use the copies to complete persons 4, 5, 6 and so on. Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
What is each person's relationship to you?		
Person 1 is my: ***Self***	Person 2 is my:	Person 3 is my:
Was this person in foster care on their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Which of these best describes where the person lives now?		
☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted living ☐ Nursing facility or other institution ☐ Hospital ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted living ☐ Nursing facility or other institution ☐ Hospital ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted living ☐ Nursing facility or other institution ☐ Hospital ☐ Other
Is this person living outside of the home?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** why is this person living outside of the home?		
Reason	Reason	Reason
Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /
▶ If in a hospital, nursing facility or other institution, what is the name of the facility?		
Name of facility	Name of facility	Name of facility
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /

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

B

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Does this person pay out of pocket for medical expenses not covered by Medicare, Medicaid or private insurance? **If yes,** tell us about the expenses.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
How much? $	How much? $	How much? $
How often?	How often?	How often?
Describe the expense:	Describe the expense:	Describe the expense:
Medical assistance may help pay for medical and hospital bills, doctor visits, medicine, Medicare premiums, in-home assistance, and nursing home and institutional care.		
▶ Is this person applying for medical assistance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what types of medical assistance does each person need? Read the descriptions below. Check the boxes for all programs each person needs. KanCare will tell you if you qualify.		
☐ Standard Medicaid (with medical card) ☐ HCBS (includes assisted living) ☐ Nursing home or other facility ☐ PACE ☐ Medicare costs **only** (no other KanCare assistance) ☐ Medically Needy (Spenddown) ☐ Working Healthy	☐ Standard Medicaid (with medical card) ☐ HCBS (includes assisted living) ☐ Nursing home or other facility ☐ PACE ☐ Medicare costs **only** (no other KanCare assistance) ☐ Medically Needy (Spenddown) ☐ Working Healthy	☐ Standard Medicaid (with medical card) ☐ HCBS (includes assisted living) ☐ Nursing home or other facility ☐ PACE ☐ Medicare costs **only** (no other KanCare assistance) ☐ Medically Needy (Spenddown) ☐ Working Healthy

Types of medical assistance

Home and Community Based Services (HCBS) is for children with disabilities and adults who have a medical need for services in the community so they can live at home or in assisted living.

Nursing home or other facility is for children with disabilities and adults who live in a nursing home, medical or mental health institution, or similar facility for a long-term stay.

Program of All-Inclusive Care for the Elderly (PACE) is for adults who live in certain counties and are age 65 or older **or** are disabled and age 55 or older. Persons who qualify get long-term care coverage through a managed care network so they can stay in the community.

Medicare Savings Program (Medicare costs) is for people who have Medicare. This program pays the Medicare Part B premiums. It may also pay Medicare co-payments and deductibles.

Medically Needy (Spenddown) is for persons in the community who have a disability or are age 65 or older. It uses medical expenses to "spend down" (lower) your income so you qualify for Medicaid.

Working Healthy is for people with disabilities who qualify. It helps them get or keep Medicaid coverage while working.

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Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Has this person ever been in a hospital or nursing facility for more than 30 days in a row?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when? (mm/dd/yyyy)		
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /
Has this person served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
VA file number	VA file number	VA file number
If this person has **not** served in the military, has this person ever been married to someone who has served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** is this person a widow or widower of someone who served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** has this person remained unmarried after the death of the spouse who served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

C Tell us about changes in your resources

Have your household **resources** changed in the last 3 months?

☐ No ☐ Yes **If yes,** tell us about the changes to your **resources**:

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

D 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 you and all others who are applying (Person 2, Person 3, etc.).

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Does this person need help paying medical bills from the last 3 months, including Medicare premiums?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Did this person have emergency care in the last 3 months to save life, organs or bodily function?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Has this person 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)		
/ /	/ /	/ /

E Tell us if anyone is disabled

We need to know if anyone in your household has a disability. We will not share personal health information given here. We will use it only to decide disability status.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
Does this person have a disability that will last at least 12 months or result in death?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Has this person ever applied for Social Security benefits? **If yes,** answer the questions below.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ What was the outcome of the Social Security application?		
☐ Approved ☐ Denied ☐ Pending ☐ In appeal	☐ Approved ☐ Denied ☐ Pending ☐ In appeal	☐ Approved ☐ Denied ☐ Pending ☐ In appeal
▶ If denied or in appeal, has the existing condition become worse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ If denied or in appeal, does this person have a new disability or condition that Social Security did not look at?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, briefly describe the disability or condition.	**If yes,** briefly describe the disability or condition.	**If yes,** briefly describe the disability or condition.

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F 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

G Tell us about work expenses

Does the primary applicant or their spouse have a disability and are they working?

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

If you are or your spouse is a person with a disability who is working, list any expenses related to the disability that allow the person to work. This includes specialized transportation to and from work, attendant care at work, attendant care to get ready for work, service animals, medications and specialized equipment or tools.

Person 1: Yourself	Your spouse
Does this person have income from working?	
☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** list any expenses related to the disability that allow the person to work.	
Type of expense	Type of expense
Monthly amount $	Monthly amount $
Type of expense	Type of expense
Monthly amount $	Monthly amount $
Type of expense	Type of expense
Monthly amount $	Monthly amount $

H Other income sources

Does the primary applicant or their spouse have income from sources other than work?

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

Type or source of income	Name of person who receives this income	Amount	How often?	Claim number, if any
Supplemental Security Income (SSI) ☐ No ☐ Yes		$		
Veterans' Benefits ☐ No ☐ Yes		$		
Railroad Retirement ☐ No ☐ Yes		$		
Child support ☐ No ☐ Yes		$		

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I Resources

We need to know about the resources of the **primary applicant** (or the parent or head of household if the primary applicant is a child) and their **spouse**, if they have one. If you need more room, attach extra pages. See the list of proof we need for each on the **back cover**.

1. Does the primary applicant or their spouse have any of the resources listed below?

Check No or Yes. **If yes,** tell us about the resource.

If the primary applicant or spouse has more than one of any of the resources listed below, use "Other" at the end of the list to add them.

Type of resource	Name on resource	Amount or value	Where resource is held *(name of bank, credit union or company)*	Account number
Cash ☐ No ☐ Yes		$		
Checking account ☐ No ☐ Yes		$		
Savings account or certificate of deposit (CD) ☐ No ☐ Yes		$		
Retirement plan ☐ No ☐ Yes		$		
Nursing facility accounts ☐ No ☐ Yes		$		
Stocks and bonds ☐ No ☐ Yes		$		
Funeral or burial plans ☐ No ☐ Yes		$		
Burial plots ☐ No ☐ Yes		$		
Other: _____ ☐ No ☐ Yes		$		
Other: _____ ☐ No ☐ Yes		$		

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2. Does the primary applicant or their spouse have any vehicles?

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

Vehicle #1		**Vehicle #2**		**Vehicle #3**	
Year		Year		Year	
Make	Model	Make	Model	Make	Model
Owner		Owner		Owner	
Estimated value $	Amount owed $	Estimated value $	Amount owed $	Estimated value $	Amount owed $
How is this vehicle used? ☐ Personal ☐ Business ☐ Both		How is this vehicle used? ☐ Personal ☐ Business ☐ Both		How is this vehicle used? ☐ Personal ☐ Business ☐ Both	

3. Does the primary applicant or their spouse have life insurance?

☐ No ☐ Yes **If yes,** complete the following. You can send a copy of the life insurance policy.

Policy owner	Insurance company	Policy number	Face value	Cash value
			$	$
			$	$
			$	$

4. Does the primary applicant or their spouse own a home?

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

Owners		Property address
Date purchased (mm/dd/yyyy) / /	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 plan to return home? ☐ No ☐ Yes

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5. Does the primary applicant or their spouse own other real estate?

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

Describe the type of property (building, lot, second home, etc.)		Is this property used as rental or income producing property? ☐ No ☐ Yes
Owners	Property address	
Date purchased (mm/dd/yyyy) / /	Value of property $	Amount owed $

6. Does the primary applicant or their spouse have a life estate or life interest in any property?

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

Describe the type of property

Owners	Property address	
Date life estate was created (mm/dd/yyyy) / /	Value of property $	Amount owed $

7. Does the primary applicant or their spouse have a trust?

☐ No ☐ Yes **If yes,** you can send a copy of your trust.

8. Does the primary applicant or their spouse have an annuity or other similar investment, including those issued as part of a retirement package?

☐ No ☐ Yes **If yes,** complete the following. You can send a copy of the annuity or investment.

Owners	Value $
Company	

For long-term care assistance, the State of Kansas must be named as the beneficiary of any annuity you own that was bought on or after February 8, 2006. You will get more information about this. When you sign the application, you are agreeing to name the State of Kansas as beneficiary (inheritor) for your annuities.

9. Does anyone owe the primary applicant or their spouse money through a promissory note or other loans?

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

Name of person who **owes you** money	How much $	What type of loan?

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10. Does the primary applicant or their spouse have other resources (such as an R.V., trailer, boat, livestock, oil rights, machinery, etc.)?

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

Resource	Owners	Value
		$
Resource	Owners	Value
		$

11. Has the primary applicant or their spouse taken a loan against any property in the last 5 years, including a second mortgage or reverse mortgage?

☐ No ☐ Yes

12. Has the primary applicant or their spouse ever waived rights to an inheritance or will?

☐ No ☐ Yes

13. Has the primary applicant or their spouse ever worked with an attorney or other professional for estate planning?

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

Name of attorney	Date (mm/dd/yyyy)
	/ /

14. Has the primary applicant or their spouse sold, traded, given away or changed ownership of any property in the last 5 years? This includes a house, money, cars or any other property.

Type of property	Value	Given or sold to	Date ownership changed	Reason it was given or sold
	$		/ /	
	$		/ /	
	$		/ /	

Proof of resources

We may ask you to send proof of all resources you report on this application, including:

- **Checking account, savings account, stocks and bonds, or CDs:** Copy of your most recent statement
- **Funeral or burial plan:** Copy of the plan, including the bill of goods and services with proof that funeral arrangements are set up as irrevocable
- **Trust or annuity**: Copy of the trust or annuity
- **Life insurance:** Letter from the life insurance company verifying owner of policy, face value, cash value, and any loans against the policy

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J 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 D and you are applying for HCBS or institutional care, you must add that person to Part D.

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

☐ No ☐ Yes **If yes,** please complete this page.

Dependents

Does this person have minor children or other family members who are dependent on them?

☐ No ☐ Yes

▶ **If yes,** please complete the following:

Dependent's name	Relationship to you	Date of birth (mm/dd/yyyy)	Person's monthly income	If a child, who does the child live with?	If a child living with another parent, list that parent's monthly income
		/ /	$		$
		/ /	$		$
		/ /	$		$

Housing expenses

Does this person have a spouse living at home or in assisted living?

☐ No ☐ Yes

▶ **If yes,** list the spouse's housing expenses below:

Type	How often?	Amount
Rent or lot rent		$
Mortgage payment		$
Property taxes, if not included in mortgage		$
Home or renter's insurance, if not included in rent or mortgage		$
Other, including condominium or home owners association (HOA) fee		$

K Read

Before you send your application, you must sign and date it on the **back cover**.
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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K 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 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 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

Sign and date this application on the back cover ▶

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

K Read and sign *(continued)*

By signing this application, I state that:

- I have read and understood the conditions on pages 14-15.
- 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 sign here (if any): ▶	Date

L Mail or fax your completed and signed application to:

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

Fax: 1-844-264-6285

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

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