Kansas
Department of Health and Environment

Certification of Need for Tuberculosis Treatment

Name (Last, First, MI):			Contact Person (Guardian, Spouse, Parent, etc.):		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone No:	County:		Phone No:		
Facility (if applicable):			Relationship to Individual:		
Date of Birth:	Gender:	Social Security Number (if applicable):			
Individual's Race	☐Asian	☐ Black	☐ Hispanic	☐ Native American	☐ White	☐ Other:
Primary Language: Spoken:			Written:		
Health Insurance Information: Do you have Medicare or other health insurance coverage?					
☐ No	☐ Yes, complete and attach copies of insurance cards:				

Company Name	Type of Coverage (Hospital, Medical, RX, etc.)	Policy/Claim Number

Authorization to Release Information

My signature on this application authorizes my employers, medical providers, financial institutions, insurance providers, benefit providers and other persons or agencies with my knowledge of my circumstances to release to the Kansas Department of Health and Environment, Division of Health Care Finance any information, including which I have applied. This release is valid from the date set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

X_____ X _____

Signature of Applicant, Guardian/Conservator, or Durable Power of Attorney — Date

FOR KDHE USE ONLY

Patient Authorized for Treatment: ☐ No ☐ Yes, Describe Treatment:

Effective Date of Treatment:	End Date of Treatment (if available):

_____ _____

Signature of KDHE Official: — Date

Return Completed Form To:

KDHE - BDCP

Tuberculosis Program

Fax #: 785-559-4224