Kansas
Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
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Veteran's Administration- KDHE Information System

To: Kansas Regional Office of Veteran's Affairs

c/o: PO Box 4444 Janesville, WI 53547

Section One: To be completed by KDHE staff

Case Number: _____

Client's First Name: _____ Middle: _____ Last: _____

Veteran's name (if different than above)

First Name_____ Middle: _____ Last:_____

Social Security Number: _____ Date of Birth: _____ VA Claim Number: _____

Name(s) of Dependent(s) /Survivor(s):

_____ _____

_____ _____

_____ _____

_____ _____

The above-named veteran and/or dependent(s)/survivor(s) are clients of the Kansas Department of Health Environment for medical assistance.

KDHE staff fill in the sections below indicating what information is needed for determination from VA staff.

In determining eligibility, the correct amount of assistance, we must verify the amount of VA benefits the clients are receiving. Therefore, we would appreciate your providing the following information:

Monthly benefit amount currently to be provided by the VA, including the aid and attendance, and unusual medical expense amounts.

The monthly benefit amount for the period:

From: _____ To: _____

The total benefit amount which has been provided by the VA since:

From: _____ To: _____

KDHE Staff Signature: _____

Date: _____

Section Two: To be completed by VA

Please supply the information requested on the first page by KDHE staff for their eligibility determination.

VA PAYMENT AMOUNT TO VETERAN/WIDOW(ER) (UNAUGMENTED)							
Name	Monthly Benefits	Amount paid From Mo/Year To Mo/Year	Amount designated Aid & Attendance or Homebound Allowance.	Designated for Unusual Medical Expenses?	Amount of Educational Benefits being Received?	Eligible for Medical Benefits?	Total Benefit Since date Indicated on Page 1

AUGMENTED AMOUNT OF VA PAYMENT ATTRIBUTABLE TO DEPENDENT(S) / SURVIVOR(S)					
Name	Monthly Benefits	Amount paid From Mo/Year To Mo/Year	Amount of Education Benefits being received	Eligible for Medical Benefits?	Total Benefits since date Indicated on page 1

Veterans Service Officer

Signature: _____

Date: _____