Statement of Continuing Eligibility

Information for Provider:

This form requests information about the medical status of the person named inside. This information will assist to determine if the person will still meet the eligibility criteria for the *Working Healthy* (WH) Program.

Working Healthy is a work incentive program which assures that Kansans with disabilities have the opportunity to participate in the workforce, become more economically independent, decrease their dependence on public benefits, and still maintain vital health care coverage.

People with disabilities of a cyclical nature, such as severe and persistent mental illness, HIV/AIDS, seizure disorder, multiple sclerosis, or cancer, who respond to medication, treatment, or support services may lose their Social Security Disability Determination due to "Medical Improvement".

Individuals meeting the *Working Healthy* "Basic Coverage" eligibility criteria may continue *Working Healthy* Medicaid Coverage as "Medically Improved". The improvement must be the medical condition that is the same as, or related to, the mental or physical condition that was the basis for their original claim with SSA.

Complete Eligibility Criteria section about this person's continuing condition, if any.
Note that medical records cannot be used in lieu of this form.

Please provide a signature.

Return promptly to the KDHE-DHCF office indicated.

If you have questions, contact the KDHE-DHCF office indicated.

Regarding:

Name:_____

Case Name: _____

Case # _____ SSN #: _____

Return to:

Working Healthy Benefits Specialist: _____

Address: _____

_____

Please return this form to your Working Healthy Benefits Specialist by _____ to avoid any negative action.

Release of Information:

I, _____, hereby authorize _____,
(Name of Provider) to provide the Department of Health and Environment, Division of Health Care Finance with information regarding my mental and/or physical condition as requested on this form. I release the above-named provider from any and all liability from giving such information. I understand that this information will be used only in the administration of the KDHE-DHCF program.
Signature of Client, Guardian, or Conservator: _____

Date: _____

Signature of Witness if by mark:_____

Date: _____

Address: _____

_____

Directions:

Please complete the ELIGIBILITY CRITERIA section. Indicate with an "X" in the boxes that apply and provide a brief statement of support.

Thank you for your time and assistance.

Required Credentials:

The following credentials are required to complete the diagnosis:

For physical conditions:

a) an M.D. or D.O.;

b) a Physician's Assistant or Advanced Registered Nurse Practitioner acting under the direction of an M.D. or D.O.

For mental illness:

a) a psychiatrist;

b) a physician or psychologist employed by or contracting with a mental health treatment facility (e.g. mental health center or psychiatric unit of a medical care facility);

c) if employed by a mental health treatment facility and acting under the direction of a physician, a registered masters level psychologist, licensed specialist social worker (e.g. licensed clinical social worker), licensed master social worker, or a registered nurse who has a specialty in psychiatric nursing.

For mental retardation:

a) a public or private agency providing diagnostic services for the mentally retarded (e.g. mental health center, state or private mental institution, school district, etc.);

b) an individual physician or psychologist licensed or certified in the State of Kansas to provide such diagnostic services.

Eligibility Criteria:

Individuals meeting the *Working Healthy* "Basic Coverage" eligibility criteria may continue *Working Healthy* coverage as "Medically Improved". The improvement must be in the medical condition that is the same as, or related to, the mental or physical disability that was the basis for their original claim.

Examples include, but are not limited to, the following:

1. Individuals with organ transplants who require medication and/or medical monitoring in order not to reject the transplanted organ;
2. Individuals with HIV/AIDS who require medication and/or medical monitoring to lengthen their life span;
3. Individuals who require medication and or monitoring for mental health problems in order to maintain employment;
4. Individuals with chronic debilitating diseases such as Multiple Sclerosis or Rheumatoid Arthritis;
5. Individuals who use motorized vehicles for mobility purposes or other assistive technology and durable medical equipment in order to perform daily activities and remain employed.
6. Individuals in end-stage renal dialysis.

Individuals who have been determined "Medically Improved" by the Social Security Administration (SSA) will be considered to have a severe medically determinable disability if a medical professional (doctor, nurse practitioner, and psychologist) documents one or more of the following health conditions. (Please indicate with an X in the box condition that relate to this person and provide a brief statement of support. Please indicate all that apply.)

☐ The individual's disability continues to substantially limit the ability to work or conduct daily life activities;

Condition:_____

Necessary Treatment Needs:

_____

_____

_____

_____

☐ The individual has a mental or physical health problem that has been stabilized by assistive technology, medication, treatment, monitoring by medical professionals, or a combination of all of these, and loss of medical services may result in a deterioration of the condition;

Condition:_____

Necessary Treatment Needs:

_____

_____

_____

☐ The loss of medical care could result in the individual's not being able to continue in the workforce or that the health problem would regress to the point where the individual would meet the SSA definition of disability, and become eligible for Social Security Disability Insurance (SSDI) payments;

Condition:_____

Necessary Treatment Needs:

_____

_____

_____

_____

Signature and Authorization: Authorization for Release of Information

YES ☐ **NO** ☐ **I consent and authorize the Department of Health and Environment, Division of Health Care Finance to release medical information contained in this document to the person whom it describes or to the guardian or caretaker of such person.**

Signature and Statement Related to Payment

Check one only:

☐ **This report was completed from my records and/or personal knowledge of the individual. No payment can be authorized for this service.**

☐ **A physical examination was required so that I could complete this form. If exam is needed payment can be made through regular Medicaid billing.**

My signature certifies that I am knowledgeable of the person's condition which I have indicated on this form.

_____ **X**_____

Provider's Name (Please Print) **Provider's Signature**

_____ _____

Telephone Number **Date:**