Elderly and Persons with Disabilities
Medical Assistance Application

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

This application is for elderly persons, persons with a disability, and families that include a child with a disability. If you are pregnant or your family does not include a child with a disability, use the ***Families with Children*** *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: 1-844-264-6285

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 this application, your household includes these people:

- Yourself (the primary applicant)
- Your legally married spouse, whether they live with you or not
- Your partner who lives with you, **only** if you have children together
- Parents of a minor child

Include **all** of the people in your household, even if you are not applying for them. Also include household members temporarily living out of the home.

Anyone who is **not** in this list will need to fill out their own application to apply for medical assistance.

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 3 people. If more than 3 people are in your household, make copies of **pages 4–12** 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
Other names used	Other names used	Other names used
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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Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Was this person in foster care on their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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 elderly or disabled 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 elderly or disabled 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.

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

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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

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 __ __ __–__ __–__ __ __ __

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)

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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 lived in the U.S. since 1996?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
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

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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
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) / /
Does this person pay out of pocket for medical expenses not covered by Medicare, Medicaid or private insurance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us about the expenses.		
How much? $	How much? $	How much? $
How often?	How often?	How often?
Describe the expense:	Describe the expense:	Describe the expense:

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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
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.*		
/ /	/ /	/ /

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 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)		
/ /	/ /	/ /

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 changes to your **household**:

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

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

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

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

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D Federal income tax information

Tell us how you and your household plan to file your taxes.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Based on your 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.*

E Tell us about deductions

We need to know about deductions on the federal income tax returns for members of your **household**, 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?

F 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)*
First and last name	First and last name	First and last name
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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G Resources

We need to know about the resources of the **primary applicant** (or the parent or head of household if the person applying 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 **page 31**.

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?

G

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
	$		/ /	
	$		/ /	
	$		/ /	

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H Jobs and other income

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

Does the primary applicant or their spouse have a job?

☐ No ☐ Yes **If yes,** tell us about **all** jobs the primary applicant and spouse have.

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
Start date (mm/dd/yyyy) / /	Start date (mm/dd/yyyy) / /	Start date (mm/dd/yyyy) / /
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: _____ $

H

Job #1 *(continued)*		Job #2 *(continued)*		Job #3 *(continued)*	
Worker's name		Worker's name		Worker's name	
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?					
☐ Tips ☐ Commissions ☐ Bonuses		☐ Tips ☐ Commissions ☐ Bonuses		☐ Tips ☐ Commissions ☐ Bonuses	
▶ **If yes,** what is the usual amount **before** deductions?					
$		$		$	
How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month	☐ Monthly ☐ Quarterly ☐ Yearly	**How often?** ☐ Weekly ☐ Every 2 weeks ☐ Twice a month	☐ Monthly ☐ Quarterly ☐ Yearly	**How often?** ☐ Weekly ☐ Every 2 weeks ☐ Twice a month	☐ Monthly ☐ Quarterly ☐ Yearly

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H Is the primary applicant or spouse 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.

You can 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?
When did the business start? / /	When did the business start? / /	When did the business start? / /
What is the estimated monthly income this year?		
$	$	$
What are the estimated monthly expenses this year?		
$	$	$
Have the monthly income or expenses changed since filing taxes last year?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how have they changed?		
Were taxes filed on this income last year?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

H

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 $

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H

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
Social Security benefits ☐ No ☐ Yes		$		
Supplemental Security Income (SSI) ☐ No ☐ Yes		$		
Veterans' Benefits ☐ No ☐ Yes		$		
Railroad Retirement ☐ No ☐ Yes		$		
Trust payments ☐ No ☐ Yes		$		
Annuity payments ☐ No ☐ Yes		$		
Other 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		$		
Child support ☐ No ☐ Yes		$		
Spousal support ☐ No ☐ Yes		$		
Other income source 1 _____ ☐ No ☐ Yes		$		
Other income source 2 _____ ☐ No ☐ Yes		$		

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

I 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

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J Other 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.
Do **not** include information about Medicaid or Medicare.

If you need to tell us about more than 3 policies, make copies of pages 23–24 before you fill them out. Attach the copies to your application.

You can send a copy of a bill showing how much you pay for the health insurance.

Tell us about health insurance policies household members have now or had in the last 3 months, other than Medicare.

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 / /

J

Policy #1 *(continued)*		Policy #2 *(continued)*		Policy #3 *(continued)*	
Type of coverage	Monthly premium	Type of coverage	Monthly premium	Type of coverage	Monthly premium
☐ Catastrophic only	$	☐ Catastrophic only	$	☐ Catastrophic only	$
☐ Dental	$	☐ Dental	$	☐ Dental	$
☐ Doctor	$	☐ Doctor	$	☐ Doctor	$
☐ Hospital	$	☐ Hospital	$	☐ Hospital	$
☐ Long-term care	$	☐ Long-term care	$	☐ Long-term care	$
☐ Medicare supplement	$	☐ Medicare supplement	$	☐ Medicare supplement	$
☐ Prescription	$	☐ Prescription	$	☐ Prescription	$
☐ Vision	$	☐ Vision	$	☐ Vision	$
☐ Other: _____	$	☐ Other: _____	$	☐ Other: _____	$

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

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

☐ No ☐ Yes

▶ **If yes,** please tell us about dependents and housing expenses on the next page.

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K

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		$

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 coverage and services separately.

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

If you have more than 3 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®

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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 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 (child, friend, lawyer, etc.):

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

☐ 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 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

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 can send your proof with the application so we can process it faster, but you do not have to send any 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 a bill showing how much you pay for the health insurance. We may also ask you to send a copy of the front and back of your insurance card.

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

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: 1-844-264-6285

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

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

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