Application/Redetermination
Medicare Savings Plans

ES-3100.8
8-22

This application is only for the following medical programs:

- Qualified Medicare Beneficiary (QMB)
- Low Income Medicare Beneficiary (LMB)
- Expanded Low Income Medicare Beneficiary (ELMB)

Estate Recovery does not apply to these programs.

Mail your signed application form to:
KanCare Clearinghouse
PO Box 3599
Topeka, KS 66601-9738

Or fax it to: 1-800-498-1255

Instructions:

- ☐ Complete the whole form. If you need more room to write, attach additional pages.
- ☐ Include copies of documents where requested.
- ☐ Sign the application at the bottom of the last page. Your application is not complete until it is signed.
- ☐ Read your rights and responsibilities on the last page.

Tell us Your Mailing Address

Last Name	**First Name**	**MI**
Address	**Apt. #**	
City	**State**	**Zip Code**
Telephone	**E-mail**	**County**

Do you want your spouse to manage your medical assistance?	☐	**No**	☐	**Yes**

Do you want someone in addition to, or instead of, your spouse to manage your medical assistance?

In addition to your spouse? ☐ **No** ☐ **Yes** **Instead of your spouse?** ☐ **No** ☐ **Yes**

If you said yes to someone in addition to, or instead of, your spouse, please list the person below and sign below:

Last Name	**First Name**	**Telephone**
Address	**Apt. #**	
City	**State**	**Zip**	**E-mail**

I appoint the person named above to be my representative to apply for and manage my medical assistance case.

Signature: _____

Language: Do you prefer a language other than English or need other media to communicate (e.g., Braille?)

☐ No ☐ Yes Spoken: _____ Written: _____

Other Media (Be specific):

Personal Information:						
	Last Name	**First Name**	**MI**	**Date of Birth**	**Social Security Number**	**Sex**
You						
Spouse						

Do you and/or your spouse have Medicare coverage?				**Medicare Claim Number**	**U.S. Citizen**		**Race/Ethnic Group (codes below)**	**City and state of birth**
You	N	Y	Circle plan type: A B C D		N	Y		
Spouse	N	Y	Circle plan type: A B C D		N	Y		

FOR Race/Ethnic Group: Use any of these codes that apply. Your coverage will not be affected if you do not answer. (**A**) American Indian/Alaskan native; (**B**) Black; (**H**) Hispanic/Latino; (**P**) Native Hawaiian/Pacific Islander; (**S**) Asian (**W**) White

Do you and/or your spouse have other health insurance?		**No**		**Yes, list below:**
List company(s) and provide copies of the card(s):				

Unearned Income:

List all sources of income for you and/or your spouse. Some examples include:

- **Social Security**
- **Veterans Benefits**
- **Pensions or Retirement**
- **Rent, Contract Sale or Promissory Note Income**
- **Support or Alimony**
- **Oil Royalties/Mineral Rights**
- **Payment from Annuities and/or Other Investments**

List all income below.

Provide Proof of All Income		Amount Before Deductions	How Often Received
Name	Type and Source of Income		

Wages or Self-Employment Income:				
1. Do you and/or your spouse work?		No		Yes, complete the following:

Provide Proof of All Income		Amount Before Deductions	How Often Received
Name	Employer Name and Address		

2. Do you have expenses related to your disability that help you stay employed, such as special transportation?

	No		Yes, list expenses and amounts:

Resources: Do you and/or your spouse have any assets and/or resources?

☐ No ☐ Yes, list below and ***provide proof.***

Type	Balance/ Value	Where is Asset Held? (Name Of Bank, Company, etc.)	Owner(s)	Account Number	Agency Use
Bank Accounts	$				
	$				
Stocks & Bonds	$				
	$				
Funeral &/or Burial Plans	$				
	$				
Trust Funds &/or Annuities	$				
	$				
Contract Sale &/or Promissory Note	$				
	$				
Other	$				

Motor Vehicles	Year	Make	Model	Owner(s)
	Year	Make	Model	Owner(s)

Life Insurance – *Provide copies of all policies.*

Policy Owner	Insurance Company	Policy Number	Face Value

Do you and/or your spouse own a home? ☐ No ☐ Yes, list value _____

Do you and/or your spouse have any other property or assets? ☐ No ☐ Yes, describe below:

Property and/or Assets Description	Property/Asset Owner	Value

STATEMENT OF UNDERSTANDING AND AGREEMENT

- I understand that disclosure of confidential information is limited to program administration purposes only.
- I agree that, upon approval for medical assistance, all rights to past, present, or future support and any rights to payment for medical care on behalf of anyone approved are automatically assigned to the Kansas Department of Health and Environment – Division of Health Care Finance (KDHE – DHCF).
- I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility. This may include computer match or other inquiries of the IRS, Social Security Administration, employers, medical providers, financial institutions, and other professional organizations, and government agencies.
- I agree to provide documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which Kansas Department for Children and Family Services (DCF) and KDHE – DHCF may obtain the necessary proof.
- I understand that my signature authorizes the use of my (our) Social Security Number(s) to administer programs I have applied for.
- I understand that I have the responsibility to use and report any third-party resources that may have a legal obligation to pay any or all of my medical expenses. I hereby authorize payments under medical assistance to be made directly to medical providers on any future unpaid bills for health services furnished me while eligible. I understand that payment for a particular service may be withheld until a determination of payment from another source is made.
- **I agree to notify of changes in income, resources (including changes in ownership), address, living arrangement and other changes which might affect my assistance within ten (10) days.**
- I understand that my application will be considered without regard to race, color, sex, age, handicaps, religion, national origin, or political belief.
- I understand that I may request a fair hearing if I disagree with an agency decision on my case and that I may be represented by any person I choose.
- I certify that I, or any persons for whom I am applying, am a U.S. citizen or an alien in lawful immigration status.
- I understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

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 knowledge of my circumstances to release to the Kansas Department for Children and Family Services and the Kansas Department of Health and Environment – Division of Health Care Finance any information, including confidential information, necessary to establish my eligibility for assistance or to administer any program for 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

Signature of Applicant, Guardian/Conservator, Or Durable Power of Attorney	Date	Signature of Contact Person or Medical Representative	Date
Signature of Applicant's Spouse	Date		
Signature of Witness (if Signed by mark)	Date	Signature of Witness (if Signed by mark)	Date