Application for Medical Assistance for Families with Children

Who can use this application?	This application is for families, children, and pregnant women. You can use this application to apply for anyone in your family, even if they have insurance now. If you are a childless adult, you may qualify for coverage through the Federal Health Insurance Marketplace at www.healthcare.gov
Use this application to see what choices you have	• Free or low-cost medical assistance from Medicaid or the Children's Health Insurance Program (CHIP) • If you are not approved for KanCare, your information may be sent to the Federal Health Insurance Marketplace. They will see if you can get other help paying for medical assistance.
Apply faster online	**GO!** Would you rather apply online? Apply faster online at www.applyforKanCare.ks.gov

Important! → Is anyone who is requesting medical assistance pregnant?

☐ Yes ☐ No

Agency Use Only

Outstationed Worker ☐

For help completing this application, call toll free: **1-800-792-4884**

A. Tell us about Yourself and the People in Your Home

Tell us about yourself. The person filling out this application is the Primary Applicant. This is usually the person who is "head of household."			
Your Name: (First, Middle, Last)		Other names used:	
Home Address:		Mailing Address (If different):	
City:	State:	City:	State:
County:	Zip:	County:	Zip:
☐ Check here if you don't have a home address. You still need to give a mailing address.			
Home Phone: ( ) —		Work Phone: ( ) —	
I would like to get information about this application by:			
Email: ☐ No ☐ Yes	Email Address:		
Text: ☐ No ☐ Yes	Cell Phone Number: ( ) —		
What language do you speak at home?		What language do you read at home?	

About Your Family

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.

Here's who you need to include on this application:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your partner who lives with you (but only if you have children together who need medical assistance)
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

Anyone else who lives with you that is not listed above will need to file their own application if they want medical assistance. You don't need to file taxes to apply for medical assistance.

Complete the questions on the next few pages for each person in your family. Start with yourself!
If you have more than 6 people in your family, please attach another sheet of paper.

Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify for medical assistance.

Persons 1, 2, and 3

Please tell us about all the people in your household. See page 2 for more information about who to include.

Start with yourself!

	Person 1 Yourself	Person 2	Person 3
First Name			
Middle Name			
Last Name			
Maiden Name			
What is this person's relationship to you?	*Self*		
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?		☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.			
Does this person have income?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
In the past year did this person (Check all that apply)	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov			
Social Security #			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		If no, skip to Section D on page 9.	
Has this person lived in a state other than Kansas in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when and where?			
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?	/ /	/ /	/ /
How many babies are expected?			

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself ⇩	Person 2 ⇩	Person 3 ⇩
First and Last Name			
Does this person have a guardian or conservator?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is their name?			
U.S. citizen?	☐ No ☐ Yes	☐ No ☐ Yes If no, complete Section C on page 8.	☐ No ☐ Yes
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Has this person delivered a baby in the last 3 months?	☐ 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
Does this person need help paying medical bills from the last 3 months? If yes, please see additional questions in Section B on page 8.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a disability that will last at least 12 months or result in death?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help with nursing home costs or in-home care?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person live with at least one child under the age of 19 and are they the main person taking care of this child?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
This person's Mother's Full Name (only answer for children)	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:
This person's Father's Full Name (only answer for children)	First: Middle: Last:	First: Middle: Last:	First: Middle: Last:

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Federal Income Tax Information We have some questions about how you plan to file your taxes. Answer these questions based on your current situation.			
Based on your current situation, does this person plan to file a federal income tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If yes, please answer questions 1 – 3. If no, please skip to question 3		
1. Will this person file jointly with a spouse?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse			
2. Does this person have any dependents on their tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list name(s) of dependents			
3. Is this person claimed as a dependent on someone else's tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list the name of the tax filer			
How is this person related to the tax filer?			
Answer the following for persons age 26 or younger			
Did this person have insurance through a job and lose it within the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, end date and reason			
Is this person a full-time student?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Was this person in Kansas foster care at the time of their 18th birthday?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a parent living outside the home?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

If there is no one else in your home, skip to Section B at the bottom of page 8.

Persons 4, 5, and 6

Please answer questions about Persons 4, 5, and 6 in your household. If you have more people to add, please attach another sheet of paper and send it with your application.

	Person 4	Person 5	Person 6
First Name			
Middle Name			
Last Name			
Maiden Name			
What is this person's relationship to you?			
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.			
Does this person have income?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
In the past year did this person (Check all that apply)	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov			
Social Security #			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, skip to Section D on page 9.		
Has this person lived in a state other than Kansas in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when and where?			
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?	/ /	/ /	/ /
How many babies are expected?			

Persons 4, 5, and 6 (continued)

Please continue to answer questions about Person 4, 5, and 6. Write their names on the first line.

	Person 4	Person 5	Person 6
First and Last Name			
Does this person have a guardian or conservator?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is their name?			
U.S. citizen?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, complete Section C on page 8.		
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Has this person delivered a baby in the last 3 months?	☐ 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
Does this person need help paying medical bills from the last 3 months? If yes, please see additional questions in Section B on page 8.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a disability that will last at least 12 months or result in death?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help with nursing home costs or in-home care?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person live with at least one child under the age of 19 and are they the main person taking care of this child?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
This person's Mother's Full Name (only answer for children)	First:	First:	First:
	Middle:	Middle:	Middle:
	Last:	Last:	Last:
	Maiden:	Maiden:	Maiden:
This person's Father's Full Name (only answer for children)	First:	First:	First:
	Middle:	Middle:	Middle:
	Last:	Last:	Last:

Persons 4, 5, and 6 (continued)

Please continue to answer questions about Person 4, 5, and 6. Write their names on the first line.

	Person 4	Person 5	Person 6
First and Last Name			
Federal Income Tax Information We have some questions about how you plan to file your taxes. Answer these questions based on your current situation.			
Based on your current situation, does this person plan to file a federal income tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If yes, please answer questions 1 – 3. If no, please skip to question 3		
1. Will this person file jointly with a spouse?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse			
2. Does this person have any dependents on their tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list name(s) of dependents			
3. Is this person claimed as a dependent on someone else's tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list the name of the tax filer			
How is this person related to the tax filer?			
Answer the following for persons age 26 or younger			
Did this person have insurance through a job and lose it within the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, end date and reason			
Is this person a full-time student?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Was this person in Kansas foster care at the time of their 18th birthday?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a parent living outside the home?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

B. Help with medical bills in the past 3 months

If you have requested help paying medical bills in the past 3 months, please answer these questions.	
Have there been any changes in the household during the last 3 months? (People moving in or out)	☐ No ☐ Yes
If yes, tell us about the household changes:	
Have there been any changes in the household income during the last 3 months?	☐ No ☐ Yes
If yes, tell us about the income changes:	

C. Immigration Status

Please provide immigration status for everyone applying who is NOT a U.S. citizen.
(Please note: Applying for KanCare medical assistance does not affect your immigration status.)

Name (First, Middle, Last)	Document Type	Immigration number	Immigration status

D. Tell Us About Jobs and Other Household Income

Does anyone in your household have a job? ☐ No ☐ Yes If yes, answer the questions below.

	Job 1	Job 2	Job 3	Job 4
Worker's Name				
Company Name				
Company Address				
Company Phone				
Start Date	/ /	/ /	/ /	/ /
How many hours working per week?				
Gross salary or hourly wage	$	$	$	$
How often are they paid?				
Date of next paycheck?	/ /	/ /	/ /	/ /
Do any of these jobs include tips, commissions or bonuses? If yes, answer the questions below.				
	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What type?				
What is the usual amount? (before deductions)	$	$	$	$
How often?				

Is anyone in your household self-employed? ☐ No ☐ Yes If yes, answer the questions below.
Self-employed means this 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.

	Self-employed 1	Self-employed 2	Self-employed 3	Self-employed 4
Self-employed person's Name				
Business Name				
What type of business is it?				
When did the business start?	/ /	/ /	/ /	/ /
Were taxes filed on this income last year?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, skip to Estimated Monthly Income			
What IRS form did you file for this income? (Check all that apply)	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other __________	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other __________	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other __________	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other __________
Reported Annual Gross Income	$	$	$	$
Reported Annual Gross Expenses	$	$	$	$
Estimated Monthly Income: (before expenses)	$	$	$	$
Monthly expenses	$	$	$	$

Predictable Changes in income: Do you have predictable income changes (up or down) during a normal year because your income is from seasonal work such as working for a school system, tax preparation, roofing, construction, or farming?

☐ No ☐ Yes If yes, please answer the questions below.

	Income 1	Income 2	Income 3	Income 4
Name of Person:				
Type of income:				
Total Income This Year:	$	$	$	$
Total Income Next Year	$	$	$	$

Does anyone in your household have income from somewhere other than work?

Examples: Social Security, VA Pension, unemployment, tribal income from gaming, college work study, or payments from a trust

☐ No ☐ Yes If yes, please answer the questions below.

	Income 1	Income 2	Income 3	Income 4
Who is the income for:				
What type of income?				
Who pays this income?				
How much?	$	$	$	$
How often?				

Does your household have any other income? ☐ No ☐ Yes If yes, please answer the questions below.

Note: You are not required to tell us about some kinds of income (such as SSI, Veteran's Payments, Child Support and tribal income obtained from natural resources, designated Indian trust land, or sales of items with cultural significance). Do you have any of these types? ☐ No ☐ Yes *You do not need to complete the section below for these types of income.*

	Income 1	Income 2	Income 3	Income 4
Who gives the money?				
Who is it given to?				
How much is given?	$	$	$	$
How often is it given?				

Deductions: Check all that apply and give the amount and how often. These are things that can be deducted on a federal income tax return. Telling us about them could make the cost of medical assistance lower. Do not include any deduction related to self-employment.

	Deduction 1	Deduction 2	Deduction 3
Name of person with deduction			
What type of deduction? (alimony, student loan interest, etc)			
How much?	$	$	$
How often?			

E. Tell us about your Family's Health Insurance

Answer these questions for everyone who has health insurance now or had it within the last 3 months. If you do not know an answer, write 'unknown.'

Health Insurance Policy Information			
	Person 1	Person 2	Person 3
First and Last Name			
Does this person have other health insurance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ended	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage Check all that apply	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____
	Person 4	Person 5	Person 6
First and Last Name			
Does this person have other health insurance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ended	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____
If anyone's insurance ended in the last 3 months, please tell us why.			

Health Coverage From Jobs

You only need to answer these questions if someone in the household is eligible for health coverage from a job and the household income is MORE than the levels listed on Helpful Hints flyer (enclosed)
Attach a copy of this page for each job that offers coverage. Tell us about the **job** that offers coverage.

EMPLOYEE Information

Employee Name		Employee SSN	

EMPLOYER Information

Employer Name		Employer Identification Number (EIN)	
Employer Address		Employer Phone Number	
City, State, Zip code			
Who can we contact about employee health coverage at this job?			
Phone Number		Email Address	

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ No (Stop here and go to the next page)

☐ Yes (Please answer questions below)

If you're in a waiting period or probationary period, when can you enroll in coverage?	/ /

List the names of anyone else who is eligible for coverage from this job.

Name:		Name:		Name:	

Tell us about the health plan offered by the employer.

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

For the lowest cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

What change will the employer make for the new year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See above question.)

How much will the employee have to pay in premiums for that plan?	$
How often?	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
Date of change (mm/dd/yyyy):	/ /

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986

F. American Indian or Alaska Native

Complete this page if you or family members are American Indian or Alaska Native.

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer these questions to make sure you and your family get the most help possible.
Note: If you have more people to include, make a copy of this page and attach.

	AI/AN Person 1	AI/AN Person 2	AI/AN Person 3
First and Last Name			
Member of a federally recognized tribe? If yes, give the name of the tribe.	☐ No ☐ Yes _____	☐ No ☐ Yes _____	☐ No ☐ Yes _____
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program or through a referral from one of these programs?	☐ No ☐ Yes If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? ☐ No ☐ Yes	☐ No ☐ Yes If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? ☐ No ☐ Yes	☐ No ☐ Yes If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? ☐ No ☐ Yes
Certain money received may not be counted for Medicaid or CHIP. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How Often? _____	$ _____ How Often? _____	$ _____ How Often? _____

G. Choose Someone to Help You With Your Medical Assistance Case

You can name a person to help you with your medical assistance case. You can choose either a "Medical Representative" or a "Facilitator."

Medical Representative is a person who can sign your application, answer questions for you, and use your medical assistance card for you. We will share information with this person. This person will get copies of letters sent to you about your case. This person is responsible for completing your review each year and for telling us about changes in your situation. The Medical Representative can be a relative, neighbor, friend, or other person you trust. You may not name someone who is trying to collect a medical debt against you.

Facilitator is a person who can help you fill out your application and help you through the application process. We will be able to share information with this person. This person will get copies of letters sent to you about your application. After your application is processed, this person is not connected to your case. A facilitator can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.

I want to appoint the following person to help me.

First and Last Name					
Organization Name					
Address Line 1					
Address Line 2					
City		State		Zip Code	
Phone Number		Email Address			
What is this person's relationship to you? (for example: child, friend, neighbor, etc)					
I appoint the above named person to be my ☐ Medical Representative, or ☐ Facilitator.					
Signature		Date			
Witness signatures are required if the signature above is made with a mark.					
Witness		Date			
Witness		Date			

Choose Your Health Plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please review the Extra Services Highlights flyer and choose your plan. If you choose, we will enroll you in that plan if eligible 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. For more information about these plans, visit www.KanCare.ks.gov

Note: For persons who are not eligible for a KanCare plan, information about coverage and services will be sent separately.

aetna®
Aetna Better Health® of Kansas
☐

sunflower health plan™
☐

UnitedHealthcare®
☐

H. Signature Page

You must sign and date this form before you send it back. **If this form is not signed, it will be returned to you.** This will cause a delay in processing your application. **Read the information below. Sign and Date.**

I understand:

- I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.
- I have the right to have information I have provided kept confidential unless directly related to the administration of Kansas medical assistance programs.
- I have to provide or apply for a Social Security number for anyone who is applying for health benefits and I authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the Social Security Administration, and Internal Revenue Service.
- It is important to provide current income, address, and household composition information, and I am responsible for reporting changes during the application process and while eligible.
- Some or all of the people for whom I am applying may receive similar health coverage under the Medicaid program if eligible.
- 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 have a legal obligation to pay any or all of the medical expense of those for whom I am applying. 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 institutional arrangement, there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institution(s) 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 provide 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 request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household are determined eligible for medical assistance.
- To help Child Support Services (CSS) in establishing and enforcing support orders (if needed) if adults in the household are determined eligible for medical assistance.
- To pay the Children's Health Insurance Program (CHIP) premium each month if I qualify for that program. The premium may be as little as $0 or as much as $50 depending on my income.

I certify:

- That everyone I am requesting health coverage for – and who is determined eligible for such coverage – is a U.S. citizen or is a non-U.S. citizen in lawful immigration status. Proof of immigration status may be required. (Exception: persons applying for emergency medical assistance under SOBRA)
- 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 physicians and other medical providers, or managed care organizations for covered medical and other health services furnished to those for whom I am applying who are eligible.
- Medical providers to release medical information to the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE DHCF), the Department for Children and Families (DCF), the Kansas Department for Aging and Disability Services (KDADS), the U.S. Department of Health and Human Services, insurance companies, and other contracted medical providers. I also authorize KDHE, DCF, and KDADS to share medical information for administrative purposes with other agencies and contractors.
- Employers, medical providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances, to release to KDHE, DCF, KDADS, or other benefit programs, any information including financial and other confidential information necessary to establish my eligibility.

My signature on this application signifies that I have read and understand the conditions above. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from this date. A copy of this authorization is as valid as the original.

Signature of Applicant (required) Date

Signature of Other Adult Applying Date

Signature of First Witness (if "X" is used) Date

Signature of Second Witness (if "X" is used) Date

Signature of Medical Representative (if applicable) Date

FOR AGENCY USE ONLY:

Would you like to register to vote today?

No _____ Yes _____ Already registered _____

For help completing this application, call toll free: **1-800-792-4884**

Information You May Have to Provide

You may have to send proof of certain things for us to process your application. You do not need to send anything now. We will contact you if we need more information.

Proof of Income

If you are reporting that you have a job
We may need copies of your paystubs for the last 30 days, or a statement from your employer with your gross income (before deductions.)

If you are reporting that you are self-employed
You must send your most recent personal and business income tax returns, including all pages and attachments.

If you are reporting that you have other income
We may need a copy of the check or benefit letter that shows the amount of income you get and how often you get the payment.

If you have unpaid medical bills from the past 3 months and would like help
We may need copies of all paystubs 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
You must send a copy of the front and back of your health insurance card.

Mail your signed application form to:

KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738

or Fax it to: 1-800-498-1255

☑ Did you remember to:

- ☐ Fill everything out?
- ☐ Tell us about everyone in your family and household, even if they don't need medical assistance?
- ☐ Sign this application on page 15?