Kansas Department of Health and Environment

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
Fax: 844-264-6285

KanCare

MEDICAL ONSET DATE VERIFICATION

Name (Last, First, Middle): _____

SSN: _____ Age: _____

Address: _____

City, State, Zip: _____

The applicant/recipient named above has recently applied or has been approved for SSI benefits. In order to determine eligibility and claim FFP on medical expenditures for the period from (Month, Day, Year) _____ to (Month, Day, Year) _____ the approximate medical onset date is necessary.

Please examine your records, and enter the medical onset date in the space below:
.

This space is for DDF use only.

Medical onset date (Month. Day, Year): _____

Remarks:
_____
_____
_____
_____
_____
_____

_____ _____
Disability determination examiner's signature Date