Kansas Department of Health and Environment

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KanCare

IM-3121
Rev. 01-17

Veteran's Administration-KDHE INFORMATION SYSTEM

To: Kansas Regional Office of Veteran's Affairs
PO Box 4444
Jamesville, WI 53547

I. TO BE COMPLETED BY KDHE STAFF

Client's Name	Name of Dependent(s)/Survivors(s)
Veteran's Name (If Different From Above)	
VA Claim Number	
Veteran's Social Security Number	
Veteran's Date of Birth	

The above-named veteran and/or dependent(s)/survivor(s) are clients of the Kansas Department of Health and Environment for medical assistance.

In determining eligibility and/or the correct amount of assistance, we must verify the amount of VA benefits the clients are receiving. Therefore, we would appreciate your providing the following information:

☐ Monthly benefit amount currently provided by the VA, including the aid and attendance and unusual medical expense amounts.

☐ Monthly benefit amount for the period _____ (Month/Year) to _____ (Month/Year)

☐ Total benefit amount which has been provided by the VA since _____ (Month/Year)

KDHE Staff Signature _____ Date _____