Kansas Department of Health and Environment

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

KanCare

Veteran's Administration- KDHE Information System

To: Kansas Regional Office of Veteran's Affairs
c/o: PO Box 4444
Janesville, WI 53547

Section one: To be completed by KDHE staff

Client's name		
Veteran's name (if different than above)		
VA Claim Number:		
Veteran's Social Security Number:		
Veteran's Date of Birth:		
Name(s) of Dependent(s)/Survivor(s)		

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

Section two: Amount to be filled in by VA staff as indicated by KDHE Staff
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.

☐ The monthly benefit amount for the period:

From:	To:

☐ The total benefit amount which has been provided by the VA since:

Date:	Amount:

KDHE Staff Signature: _____ **Date:** _____

Section Two: To be completed by VA

VA PAYMENT AMOUNT TO VETERAN/WIDOW(ER) (UNAUGMENTED)							
Name	Monthly Benefit	Paid in Mo/Year to Mo/Year	What Amount Designated for Aid and Attendance or Homebound Allowance?	What Amount Designated for Unusual Medical Expenses?	Amount of Educational Benefits Being Received	Eligible for Medical Benefits?	Total Benefit Since Date Indicated on Page 1

AUGMENTED AMOUNT OF VA PAYMENT ATTRIBUTABLE TO DEPENDENT(S) / SURVIVOR(S)					
Name	Monthly Benefit	Paid in Mo/Year to Mo/Year	Amount of Educational Benefits Being Received	Eligible for Medical Benefits?	Total Benefit Since Date Indicated on Page 1

Veterans Service Officer Signature: _____ **Date:** _____