Application Supplement to KC1500

Who can use this supplement?	This form is for applicants who have already filled out an application for the Elderly and Persons with Disabilities, but need help under our family medical programs. This form is not a valid application by itself.

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

☐ Yes ☐ No

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:
Home Phone: ( ) —		Work Phone: ( ) —	

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

Complete the questions on the next few pages for each person in your family, starting 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.

Agency Use Only

Outstationed Worker ☐

Persons 1, 2, and 3

Please tell us about all the people in your household. See page 1 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*		
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?			
How many babies are expected?			
Does this person need help paying medical bills from the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
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
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 (include Maiden)	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:
This person's Father's Full Name	First: Middle: Last:	First: Middle: Last:	First: Middle: Last:
Did this person have insurance that ended in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, why?			
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 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

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 this form.

	Person 4	Person 5	Person 6
First Name			
Middle Name			
Last Name			
Maiden Name			
What is this person's relationship to you?			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?			
How many babies are expected?			
Does this person need help paying medical bills from the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
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
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 (include Maiden)	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:
This person's Father's Full Name	First: Middle: Last:	First: Middle: Last:	First: Middle: Last:
Did this person have insurance that ended in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, why?			
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 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. Tell us about Income Deductions

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 a little lower. Do not include any deduction related to your 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?			

Use this space to write additional information

C. Health Coverage From Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. 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 ☐ 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 ☐ 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

D. 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 the following 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? _____

E. 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 _____

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