A Guide to Completing the Medicare Savings Programs Application/ Redetermination

A Guide to Completing the Medicare Savings Programs Application/ Redetermination

- **For those who are receiving Medicare coverage**

This guide was created in partnership with the KanCare Ombudsman Office and the Kansas Department of Health and Environment.

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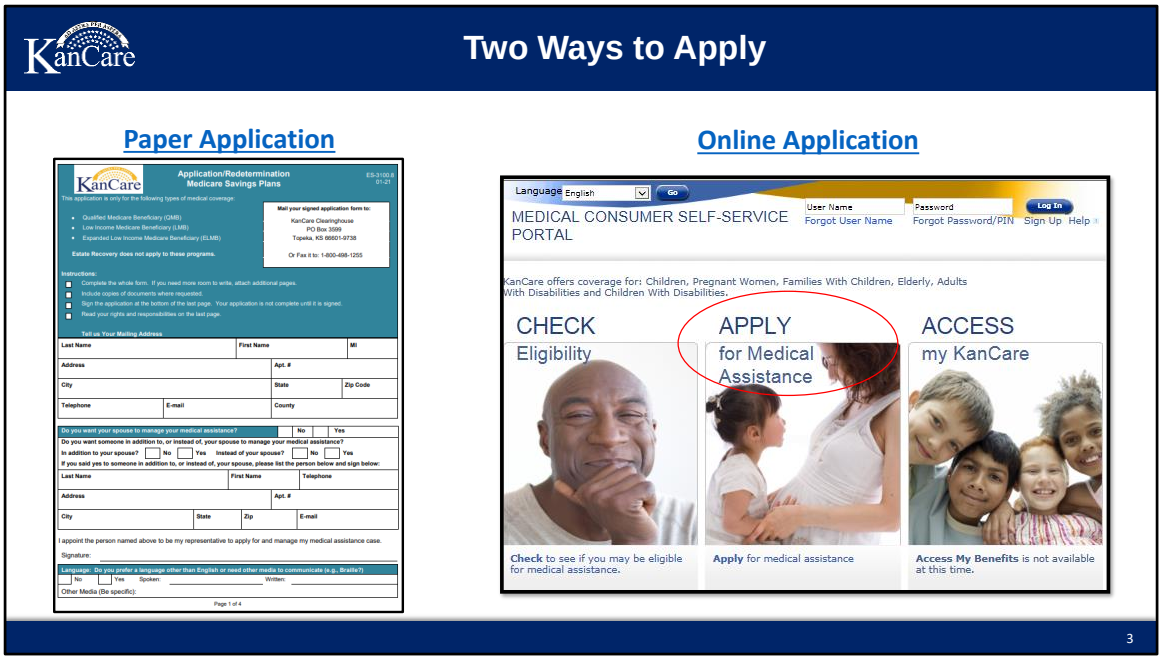
Welcome to the KanCare Application Guide. This guide will help you with filling out the sections of the Application/Redetermination Medicare Savings plan.

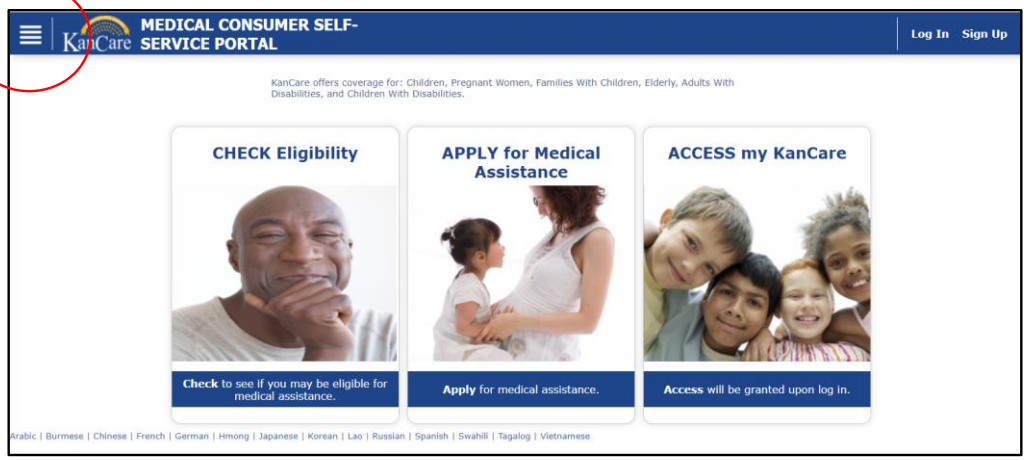


There are two ways to apply. Applicants may use the paper application or apply online at kancare.ks.gov through the self-service portal. This guide will focus on the paper application. The paper application can be found at www.kancare.ks.gov under the CONSUMERS tab, Apply for KanCare.

The online application changes depending on the data that is entered by each applicant; it will work for all the possible KanCare programs.

URL: https://kancare.ks.gov/consumers/apply-for-kancare, Link to online application: Apply for KanCare (ks.gov)

How to use the Medical Consumer Self-Service Portal



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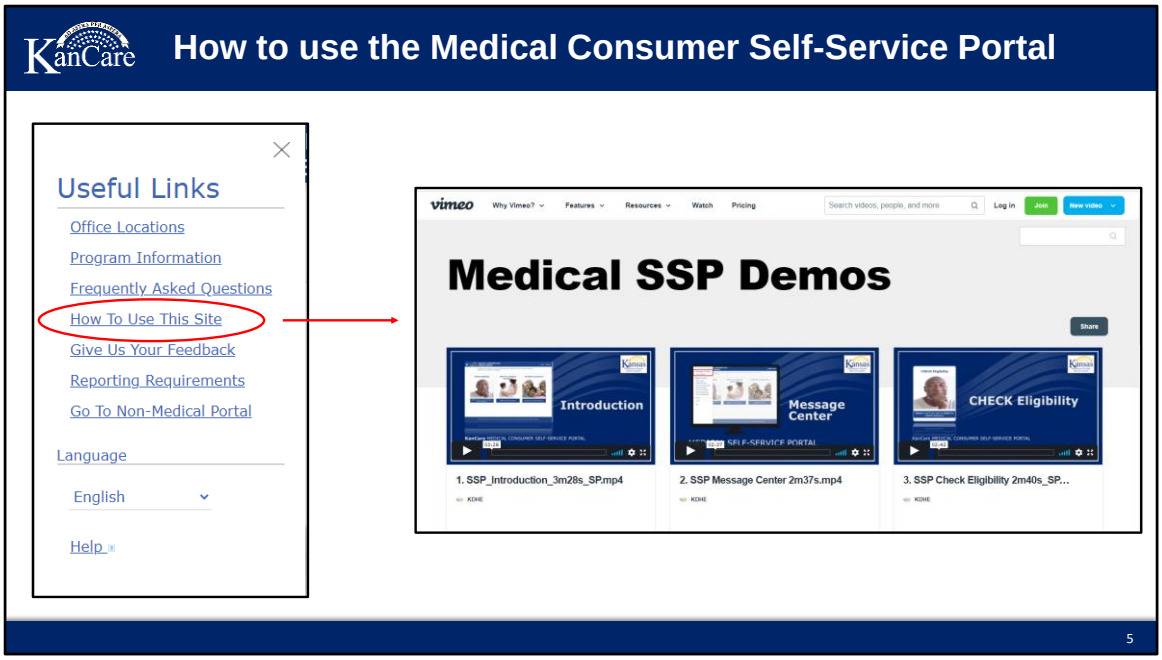
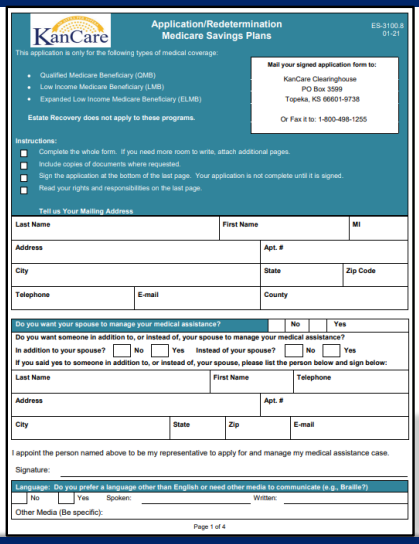
To learn more about how to use the Medical Consumer Self-Service Portal also known as the online application go to www.ApplyForKanCare.ks.gov and click on the hamburger or menu icon to the top left of the self-service portal landing page.



After clicking on the hamburger icon, the applicant will see the Useful Links tab open. Click on the link that says, “How To Use This Site." It will then take the applicant to another page that will have the link to the Medical SSP Demos Vimeo page, where they can watch videos on how to use the Medical Consumer Self-Service Portal.

Page 1



KanCare

Application/Redetermination
Medicare Savings Plans

ES-3100.8
01-21

This application is only for the following types of medical coverage:

- Qualified Medicare Beneficiary (QMB)
- Low Income Medicare Beneficiary (LMB)
- Expanded Low Income Medicare Beneficiary (ELMB)

Estate Recovery does not apply to these programs.

Mail your signed application form to:
KanCare Clearinghouse
PO Box 3599
Topeka, KS 66601-9738

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

Instructions:
- ☐ Complete the whole form. If you need more room to write, attach additional pages.
- ☐ Include copies of documents where requested.
- ☐ Sign the application at the bottom of the last page. Your application is not complete until it is signed.
- ☐ Read your rights and responsibilities on the last page.

Tell us Your Mailing Address

Last Name	First Name	MI
Address	Apt. #	
City	State	Zip Code
Telephone	E-mail	County

Do you want your spouse to manage your medical assistance? ☐ No ☐ Yes

Do you want someone in addition to, or instead of, your spouse to manage your medical assistance?

In addition to your spouse? ☐ No ☐ Yes **Instead of your spouse?** ☐ No ☐ Yes

If you said yes to someone in addition to, or instead of, your spouse, please list the person below and sign below:

Last Name	First Name	Telephone
Address	Apt. #	
City	State	Zip	E-mail

I appoint the person named above to be my representative to apply for and manage my medical assistance case.

Signature: _____

Language: Do you prefer a language other than English or need other media to communicate (e.g., Braille?)

☐ No ☐ Yes Spoken: _____ Written: _____

Other Media (Be specific):

Page 1 of 4

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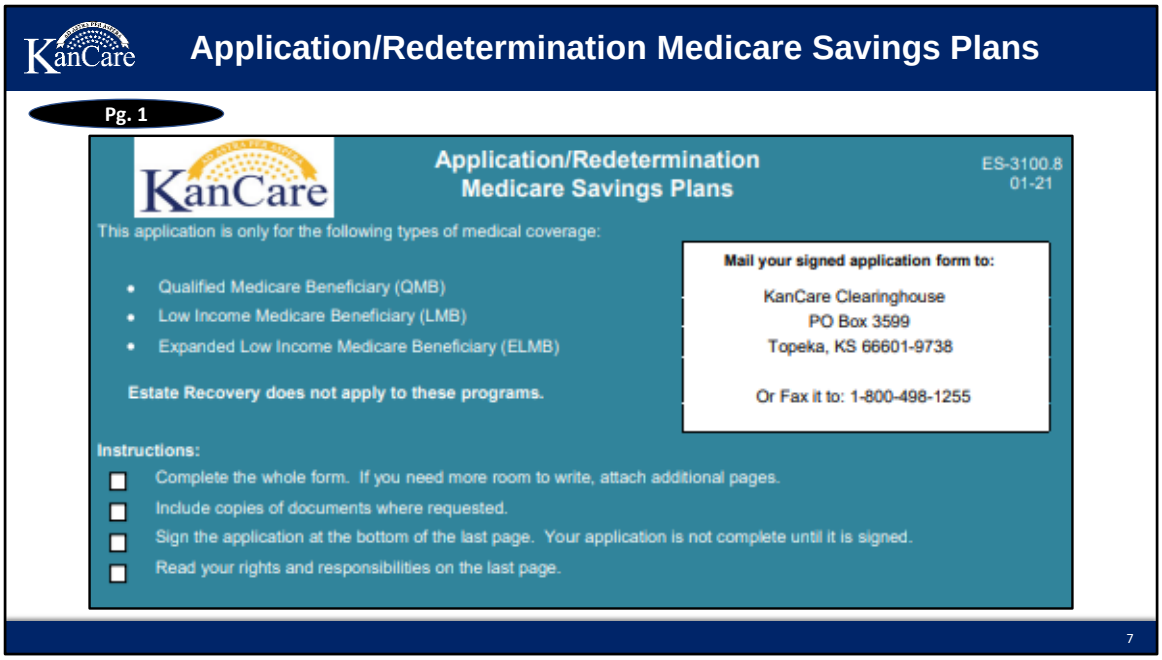
This is the first page of the paper application for the Medicare Savings Program or MSP Only Application. Next, we will go through each section of the first page.



This is an application only for the following types of medical coverage: Qualified Medicare Beneficiary (QMB) Low Income Medicare Beneficiary (LMB) and Expanded Low Income Medicare Beneficiary (ELMB).
Estate Recovery does not apply to these Medicare Saving Programs.
Be sure to read the instructions and check the box for each after you have completed each step.

These instructions include:

Complete the whole form. If you need more room to write, attach additional pages.

Include copies of documents where requested. **The applicant and/or their spouse can send their proof with the application so we can process it faster, but the applicant does not have to send any proof right now. We will try to obtain this proof through other means. We contact the applicant later for this proof if we cannot obtain it on our own. The applicant should submit their application as soon as possible.**

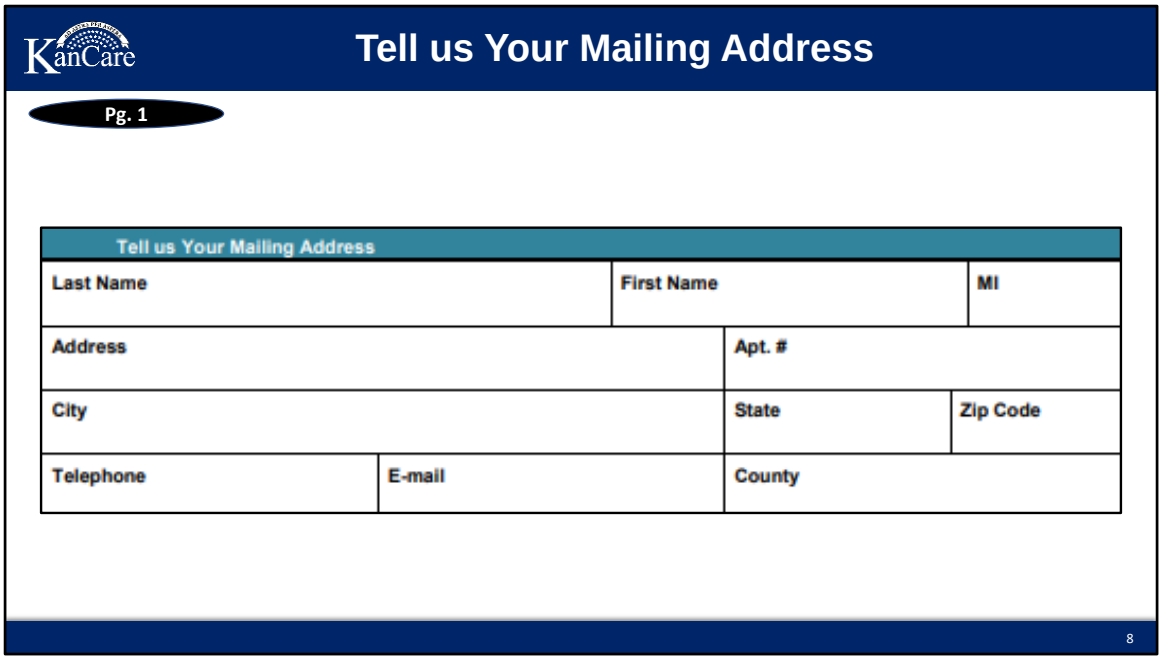
Sign the application at the bottom of the last page. Your application is not complete

until it is signed.

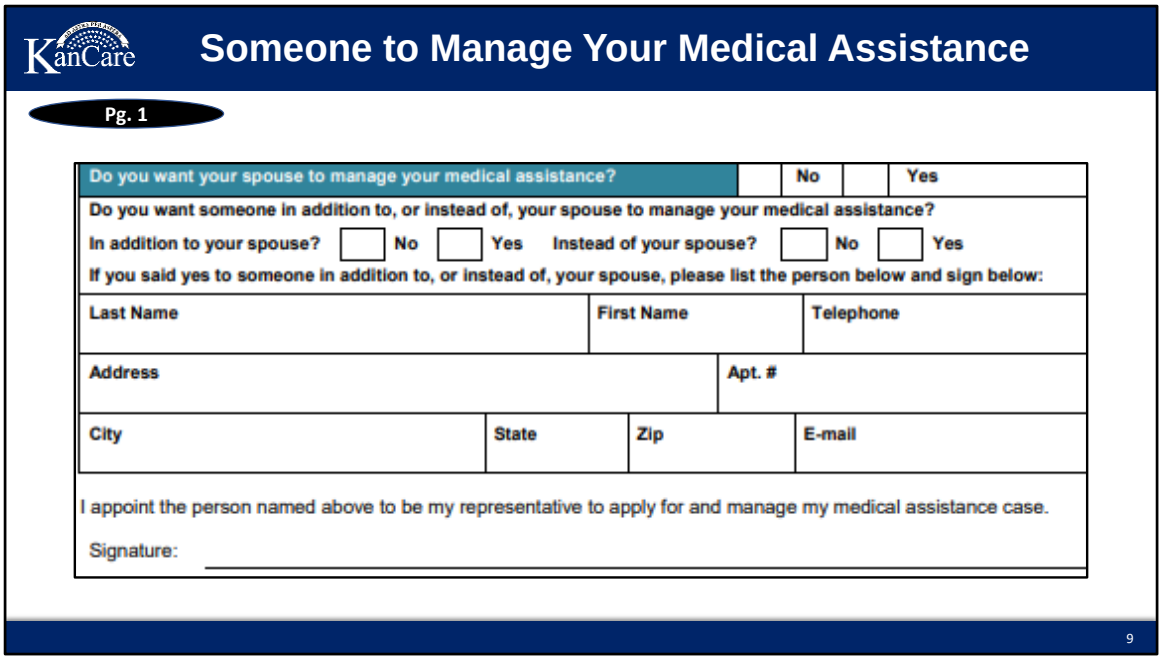
Read your rights and responsibilities on the last page.

See the white box to the top right of the first page for the mailing address for the KanCare Clearinghouse. This is where the applicant will mail their signed application form to.

Those who do not currently receive Medicare coverage can apply for the Medicare Savings Program up to 30 days prior to starting Medicare coverage.



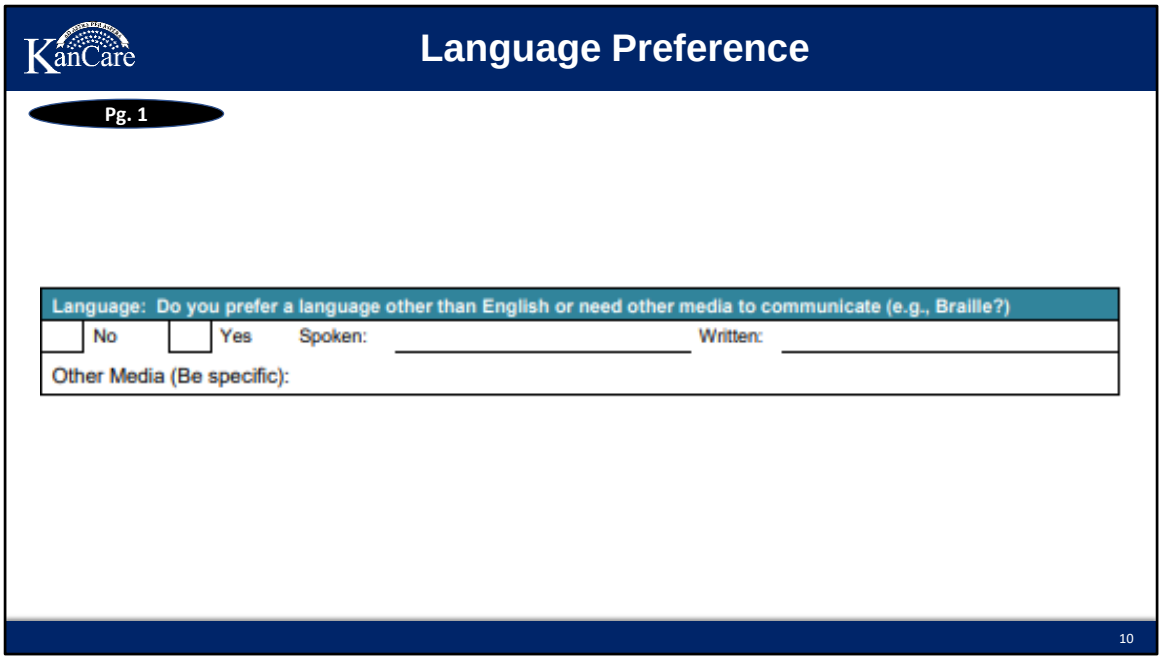
Tell us your mailing address. Here, the applicant will print their first and last name, middle initial, address, telephone number, email, and county.



This section asks, “Do you want your spouse to manage your medical assistance?” Here the applicant will check “No” or “Yes. This section also asks, “Do you want someone in addition to, or instead of, your spouse to manage your medical assistance?” Check “No” or “Yes” next to the two options provided.

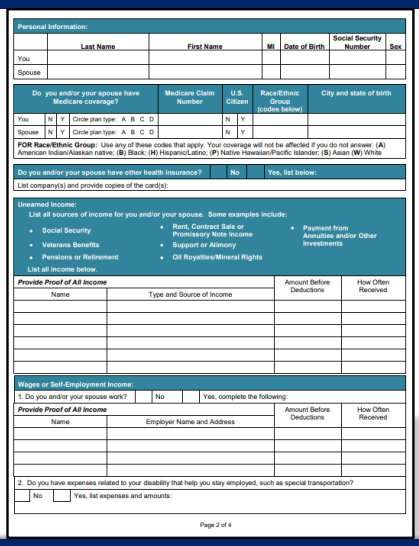
If the applicant checks “Yes” to “someone in addition to, or instead of, your spouse, please list the person below and sign below:”, They should fill in the last name and first name, telephone number, address, and email of the person they are appointing to manage their medical assistance case.

The applicant will also sign their name under “I appoint this person to be my representative to apply for and manage my medical assistance case.”



This section asks, “Do you prefer a language other than English or need other media to communicate”. **The applicant and/or their should provide their preferred spoken and written language in the lines provided.**

Page 2



Personal Information:

	Last Name	First Name	MI	Date of Birth	Social Security Number	Sex
You						
Spouse						

Do you and/or your spouse have Medicare coverage?				Medicare Claim Number	U.S. Citizen		Race/Ethnic Group (codes below)	City and state of birth
You	N	Y	Circle plan type: A B C D		N	Y		
Spouse	N	Y	Circle plan type: A B C D		N	Y		

FOR Race/Ethnic Group: Use any of these codes that apply. Your coverage will not be affected if you do not answer. (**A**) American Indian/Alaskan native; (**B**) Black; (**H**) Hispanic/Latino; (**P**) Native Hawaiian/Pacific Islander; (**S**) Asian (**W**) White

Do you and/or your spouse have other health insurance? ☐ No ☐ Yes, list below:

List company(s) and provide copies of the card(s).

Unearned Income:

List all sources of income for you and/or your spouse. Some examples include:

- Social Security
- Veterans Benefits
- Pensions or Retirement
- Rent, Contract Sale or Promissory Note Income
- Support or Alimony
- Oil Royalties/Mineral Rights
- Payment from Annuities and/or Other Investments

List all income below.

Provide Proof of All Income		Amount Before Deductions	How Often Received
Name	Type and Source of Income		

Wages or Self-Employment Income:

1. Do you and/or your spouse work? ☐ No ☐ Yes, complete the following:

Provide Proof of All Income		Amount Before Deductions	How Often Received
Name	Employer Name and Address		

2. Do you have expenses related to your disability that help you stay employed, such as special transportation?

☐ No ☐ Yes, list expenses and amounts:

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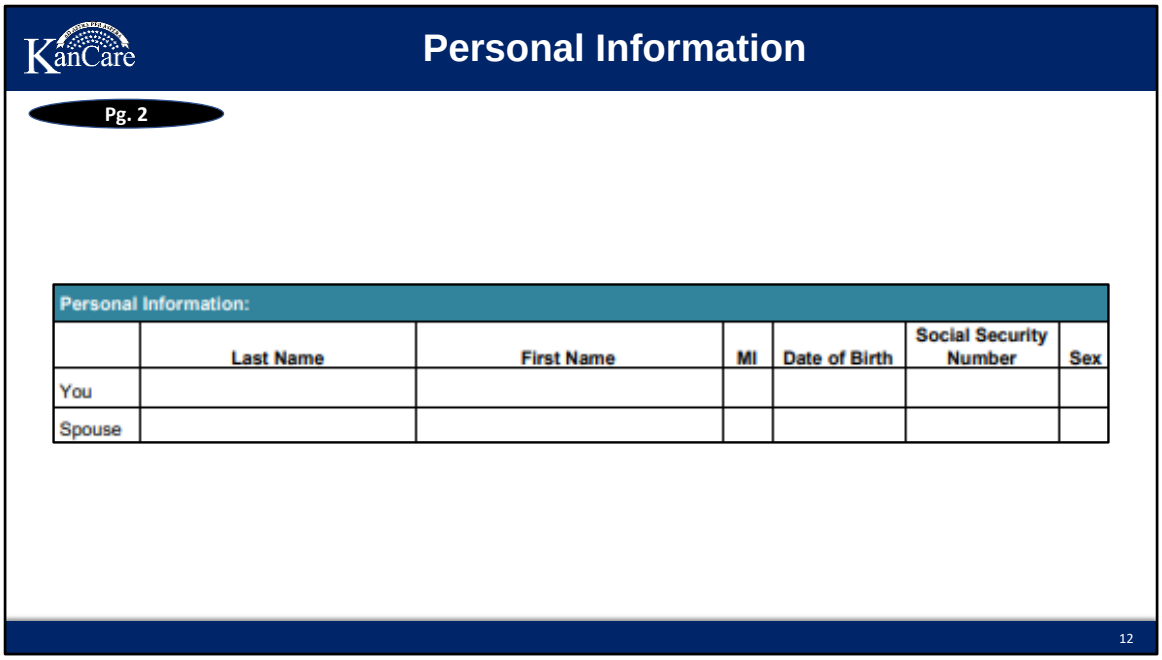
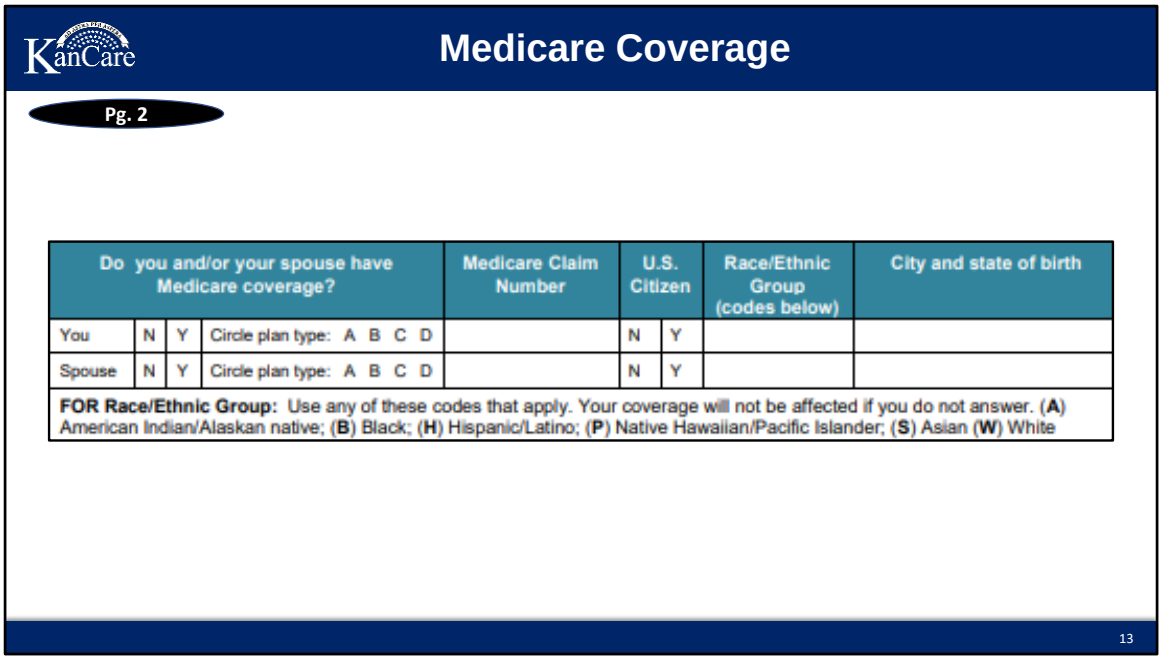
This is the second page of the paper application for the Medicare Savings Program Only Application. Next, we will go through each section of the second page.

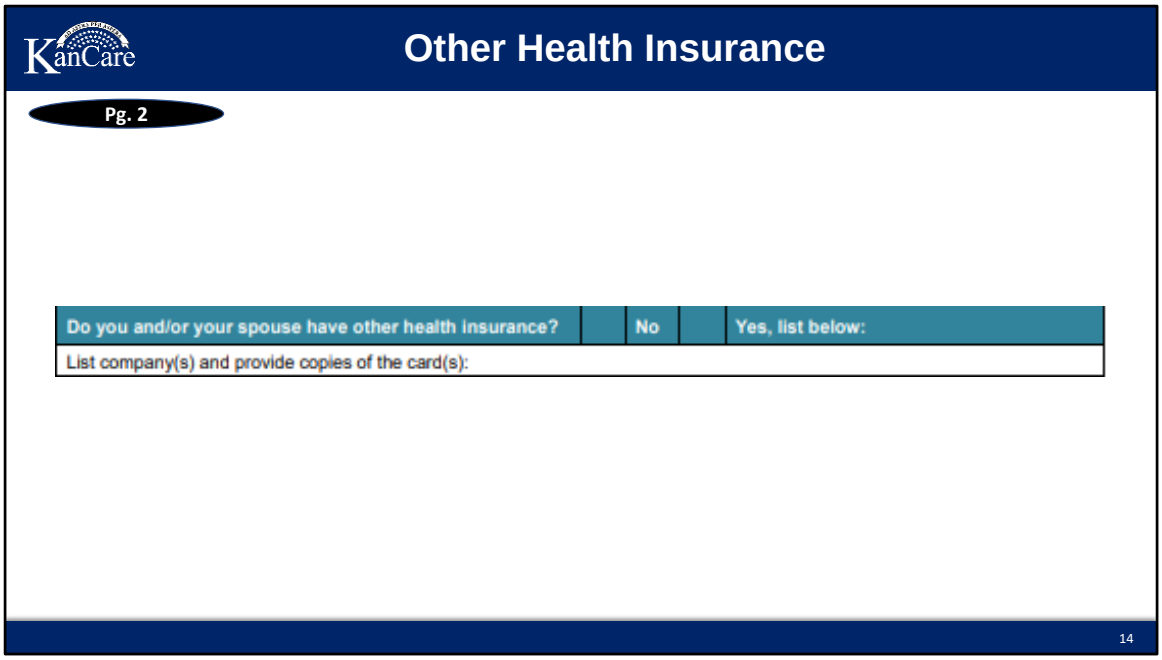


Personal Information: This section is where the applicant will put the last name, first name, middle initial, date of birth, social security number, and sex for the applicant and their spouse if applicable.

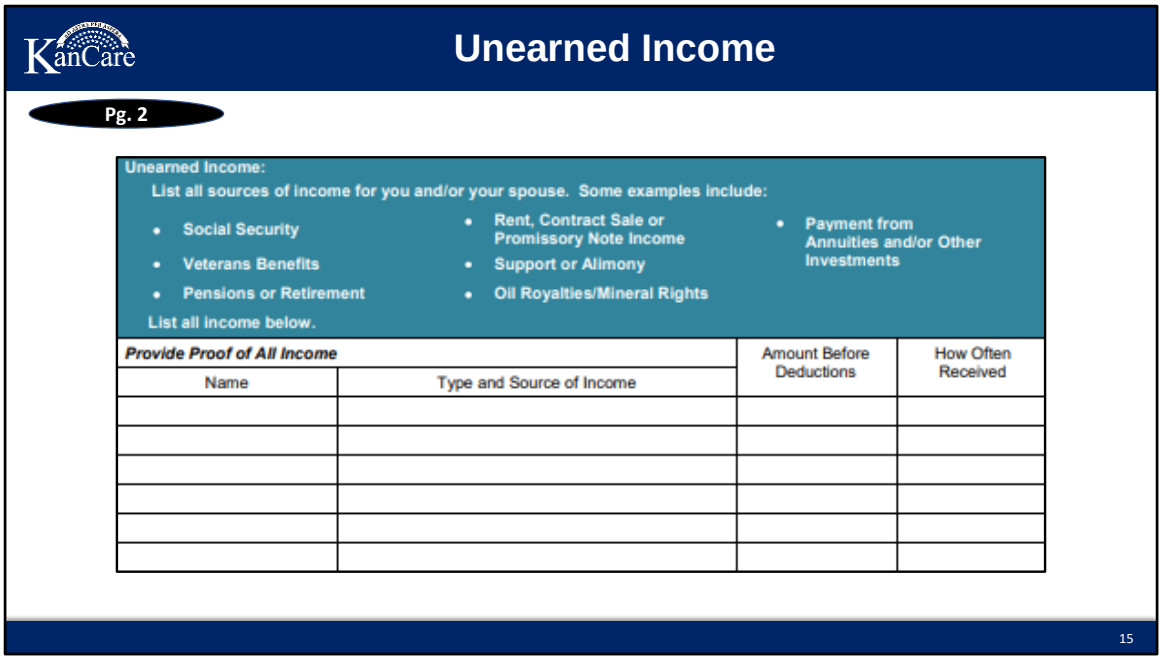
For the Medicare Savings Programs the applicant does not need to include minor children living in the household. If coverage is needed for those children please fill out the Medical Assistance for Families with Children Application.



This section asks, “Do you and/or your spouse have Medicare coverage?” If the applicant and/or their spouse has Medicare coverage, they will enter that information here. Circle “N” for “No” or “Y” for “Yes”. If yes, circle the plan types, and provide the Medicare claim number. Under U.S. Citizen circle “N” or “Y”. Read the race/ethnic group message below and provide the applicable code under “Race/Ethnic Group”. Finally, the applicant and their spouse (if applicable) will enter the city and state of their birth.



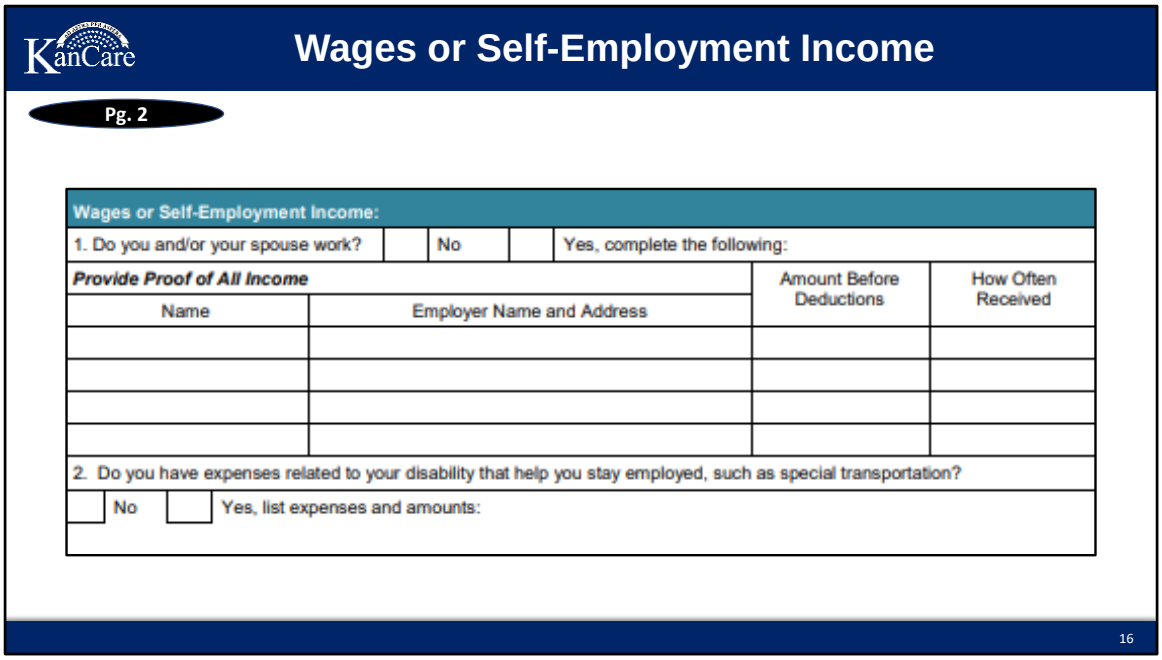
This section asks, “Do you and/or your spouse have other health insurance?” The applicant will check “No” or “Yes”. If “yes”, list the company or companies here. The applicant can submit copies of the front and back of their medical cards.



Here is where the applicant should list all sources of income for themselves and their spouse if applicable. Some examples include: Social Security, Veterans Benefits, Pensions or Retirement, Rent, Contract Sale or Promissory Note Income, Support or Alimony, Oil Royalties/Mineral Rights, and Payments from Annuities and/or other Investments.

Examples of a retirement plan could be an IRA, 401k or other accounts or funds set up for retirement.

The applicant may provide proof of all income. If we need proof, we may ask for it later.

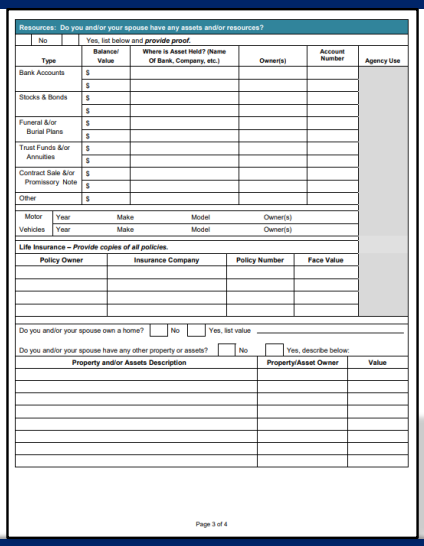


This section asks, “Do you and/or your spouse work?” the applicant will check “No” or “Yes”. If yes, they will complete the following sections. If no, check “No” then move to page 3.

The applicant will put the name, the employers name and address, income made before deductions and how often it is received.

The second question in this section asks, “Do you have expenses related to your disability that help you stay employed, such as special transportation?” the applicant will check “No” or “Yes”. If yes, list the expenses and amounts in this section. If more room is needed, the applicant can attach an additional sheet of paper to the application.

Page 3 Assets and/or Resources



Resources: Do you and/or your spouse have any assets and/or resources?

☐ No ☐ Yes, list below and ***provide proof.***

Type	Balance/ Value	Where is Asset Held? (Name Of Bank, Company, etc.)	Owner(s)	Account Number	Agency Use
Bank Accounts	$				
	$				
Stocks & Bonds	$				
	$				
Funeral &/or Burial Plans	$				
	$				
Trust Funds &/or Annuities	$				
	$				
Contract Sale &/or Promissory Note	$				
	$				
Other	$				

Motor Vehicles	Year	Make	Model	Owner(s)
	Year	Make	Model	Owner(s)

Life Insurance – *Provide copies of all policies.*

Policy Owner	Insurance Company	Policy Number	Face Value

Do you and/or your spouse own a home? ☐ No ☐ Yes, list value _____

Do you and/or your spouse have any other property or assets? ☐ No ☐ Yes, describe below:

Property and/or Assets Description	Property/Asset Owner	Value

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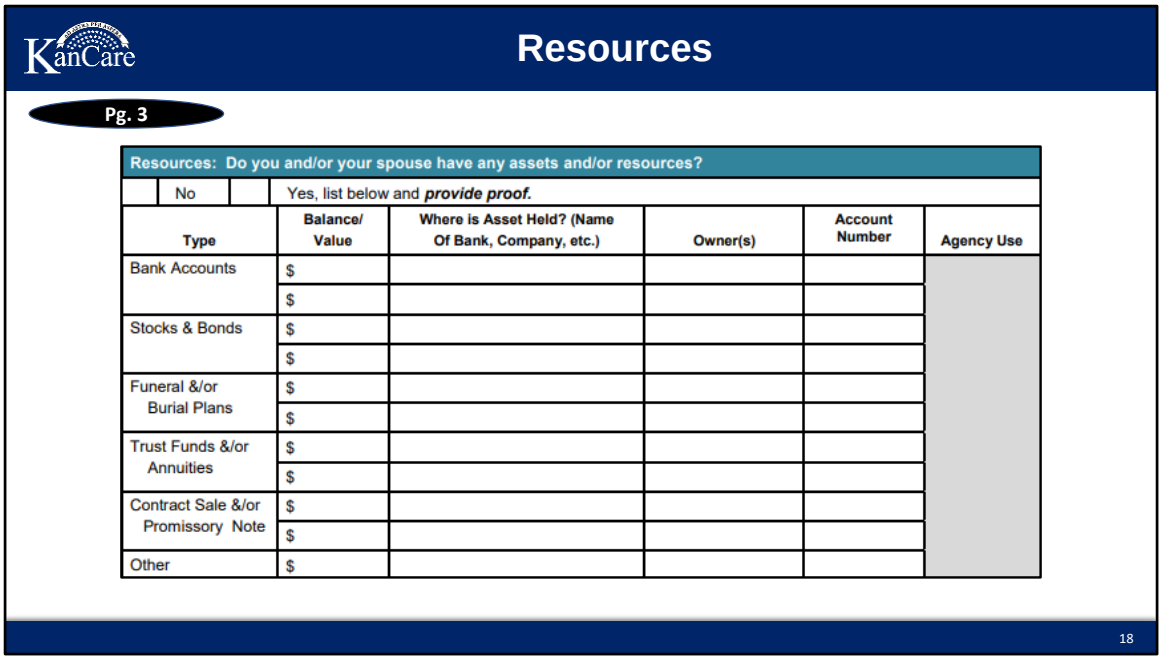
This is the third page of the paper application for the Medicare Savings Program Only Application. Now, we will go through each section of the third page.



This section is where the applicant will put information about Bank Accounts, Stocks & Bonds, Funeral &/or Burial Plans, Trust Funds &/or Annuities, and Contract Sale &/or Promissory Notes.

If the applicant or spouse have a checking or savings account they will need to write the balance or value, where the account is held such as the name of bank or the company, the names of the owners, and the account number. If each spouse has their own checking and/or savings accounts, they will need to list those separately with the correct names on each account. If they have combined accounts then both of their names should go on the resource.

Please provide information about stocks and bonds. It is important to note the type of stock and/or bond. We may request a statement showing the current value if it is not provided with the application.

Please provide information on any funeral or burial plans and burial plots. The value in addition to if it is revocable or irrevocable, will be taken in consideration when determining if the resource is exempt or countable. We may request verification documents for these resources. Funeral homes are familiar with these types of

requests when someone applies for Medicaid.

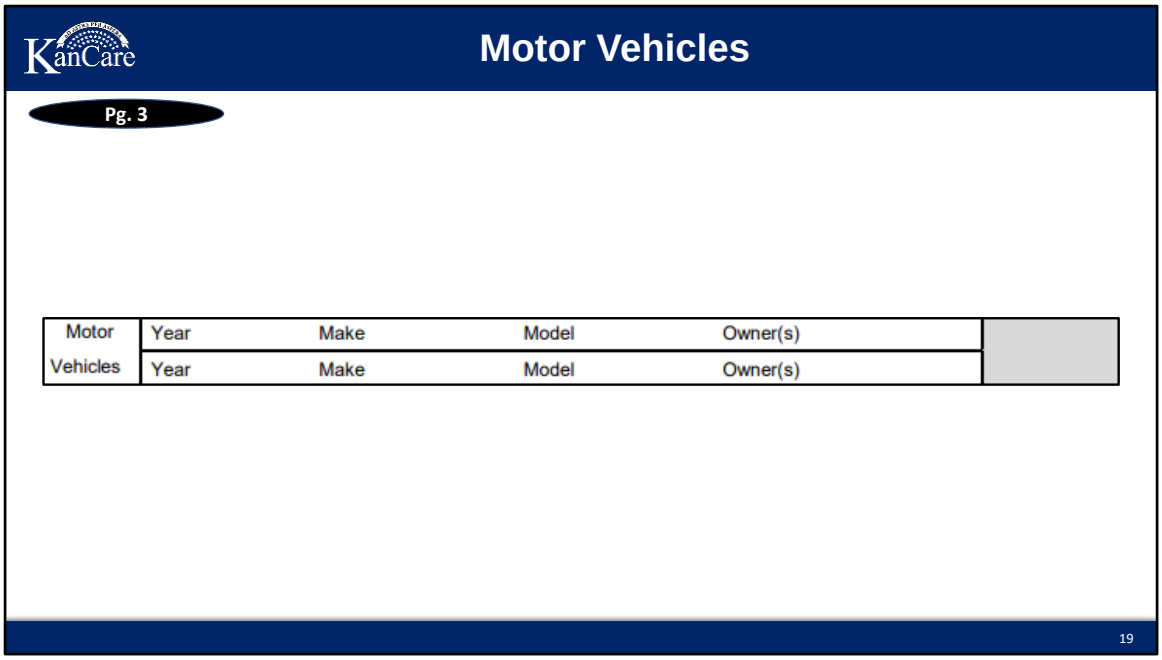
If the applicant and/or their spouse owns a trust, the resources that are titled in the trusts name must also be reported on the application. If marked yes, we will need a full copy of the entire trust along with all of the schedules and amendments. A copy of the contract is also needed.

If the applicant and/or their spouse owns an annuity the State of Kansas must be named as the beneficiary of any annuity they own which was purchased on or after February 8, 2006. The applicant agrees to make this assignment when they sign the application.

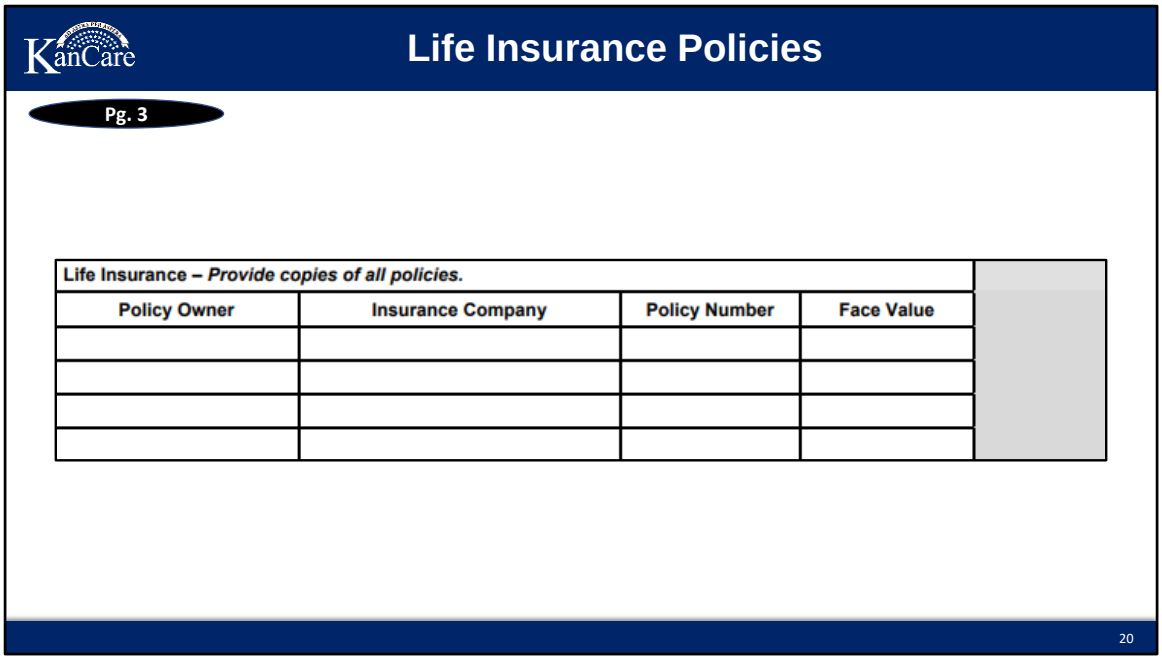
If the applicant and/or their spouse has contract sales and or a promissory note put that in the contract sale or promissory note section. An example is the applicant or spouse loaned someone $8,000 six months ago and it hasn't been repaid in full.

The "Other" section is provided if the applicant and/or their spouse has more than two of any resource or if a resource is not listed in the "Type" column. For example if the applicant has an Individual Retirement Account or IRA, they can list that here.

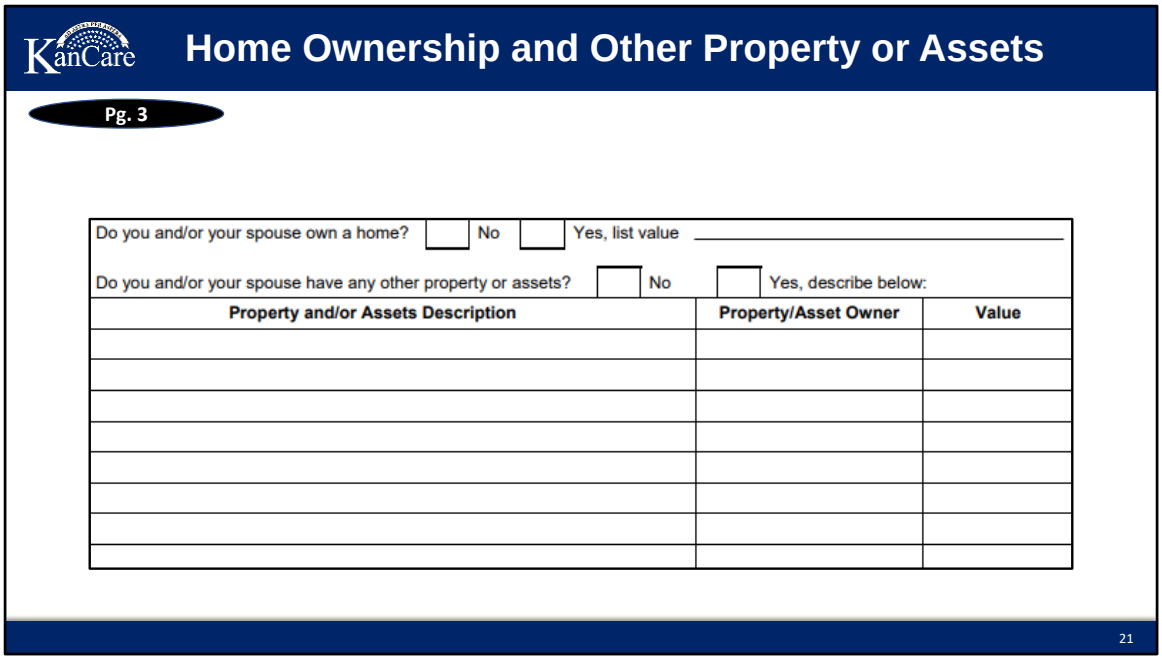
If the applicant needs more room, they can attach an additional sheet of paper to the application.



This section is where the applicant will put information about motor vehicles. If the applicant has a motor vehicle, the year, make, model, and owner or owners will go here.



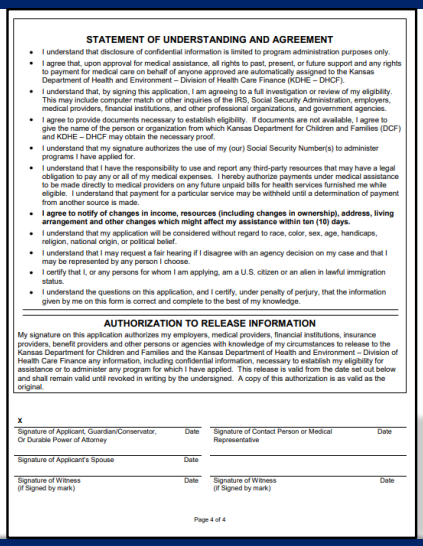
If the applicant or their spouse have a life insurance policy they will put the policy owner, insurance company, policy number, and the face value here. If the applicant has a life insurance policy, they will need to provide copies of each policy. To verify a policy, we suggest that the applicant request a letter from the insurance company which will contain the policy number, policy owner, type of policy whether it is a whole life or term policy, the face value, the cash value, and any loans which have been taken against the policy.



This section asks, “Do you and/or your spouse own a home?” check “No” or “Yes”, if yes, list the value of the home.

The next question asks, “Do you and/or your spouse have any other property or assets?” check “No” or “Yes”, if yes, describe below in the spaces provided.

Page 4: Statement of Understanding and Agreement, Authorization to Release Information, and Signature Page



STATEMENT OF UNDERSTANDING AND AGREEMENT

- I understand that disclosure of confidential information is limited to program administration purposes only.
- I agree that, upon approval for medical assistance, all rights to past, present, or future support and any rights to payment for medical care on behalf of anyone approved are automatically assigned to the Kansas Department of Health and Environment – Division of Health Care Finance (KDHE – DHCF).
- I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility. This may include computer match or other inquiries of the IRS, Social Security Administration, employers, medical providers, financial institutions, and other professional organizations, and government agencies.
- I agree to provide documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which Kansas Department for Children and Families (DCF) and KDHE – DHCF may obtain the necessary proof.
- I understand that my signature authorizes the use of my (our) Social Security Number(s) to administer programs I have applied for.
- I understand that I have the responsibility to use and report any third-party resources that may have a legal obligation to pay any or all of my medical expenses. I hereby authorize payments under medical assistance to be made directly to medical providers on any future unpaid bills for health services furnished me while eligible. I understand that payment for a particular service may be withheld until a determination of payment from another source is made.
- **I agree to notify of changes in income, resources (including changes in ownership), address, living arrangement and other changes which might affect my assistance within ten (10) days.**
- I understand that my application will be considered without regard to race, color, sex, age, handicaps, religion, national origin, or political belief.
- I understand that I may request a fair hearing if I disagree with an agency decision on my case and that I may be represented by any person I choose.
- I certify that I, or any persons for whom I am applying, am a U.S. citizen or an alien in lawful immigration status.
- I understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

AUTHORIZATION TO RELEASE INFORMATION

My signature on this application authorizes my employers, medical providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to the Kansas Department for Children and Families and the Kansas Department of Health and Environment – Division of Health Care Finance any information, including confidential information, necessary to establish my eligibility for assistance or to administer any program for which I have applied. This release is valid from the date set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

x

Signature of Applicant, Guardian/Conservator, Or Durable Power of Attorney — Date

Signature of Contact Person or Medical Representative — Date

Signature of Applicant's Spouse — Date

Signature of Witness (If Signed by mark) — Date

Signature of Witness (If Signed by mark) — Date

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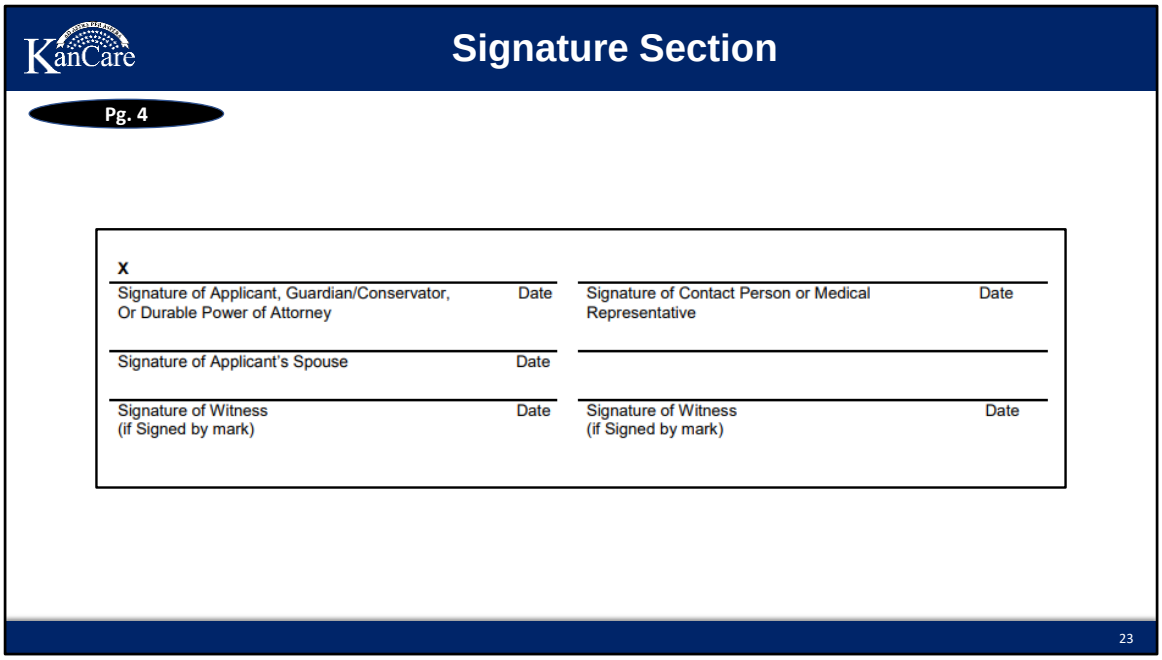
This is the fourth page of the paper application for the Medicare Savings Program Only Application. The applicant and/or applicants should read the Statement of Understanding and Agreement and the Authorization to Release Information sections thoroughly before signing the appropriate lines at the bottom of the page.



At the bottom of the fourth page is where the applicant will sign the application. There are multiple lines for different types of signatures.

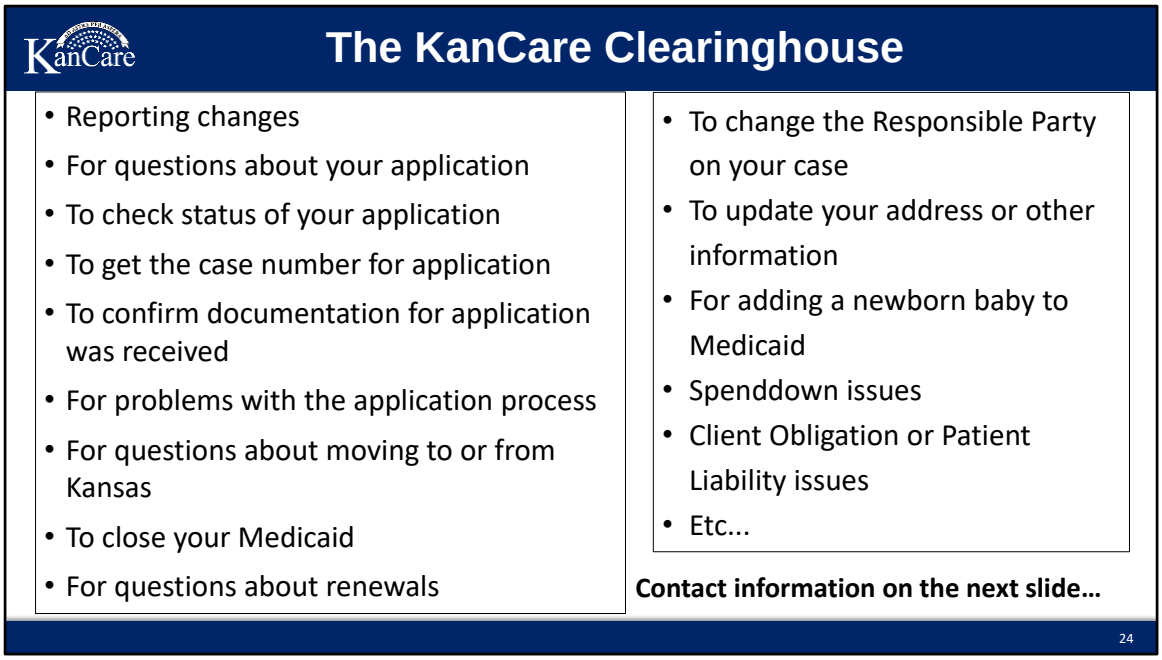
The first line is where the applicant, their guardian or Conservator, or their durable power of Attorney can sign.

The next signature line is where the Contact Person or Medical Represented as appointed on the first page of the application will sign.

If the applicant has a spouse they can sign above the section for the Applicants Spouse.

The last two signature lines are where the witnesses should sign if the main signature was signed by a mark.

The application must be singed in order for the KanCare Clearinghouse to process for MSP eligibility.



Now that we have gone through the Medicare Savings Program Only Application, we would like to introduce the KanCare Clearinghouse.

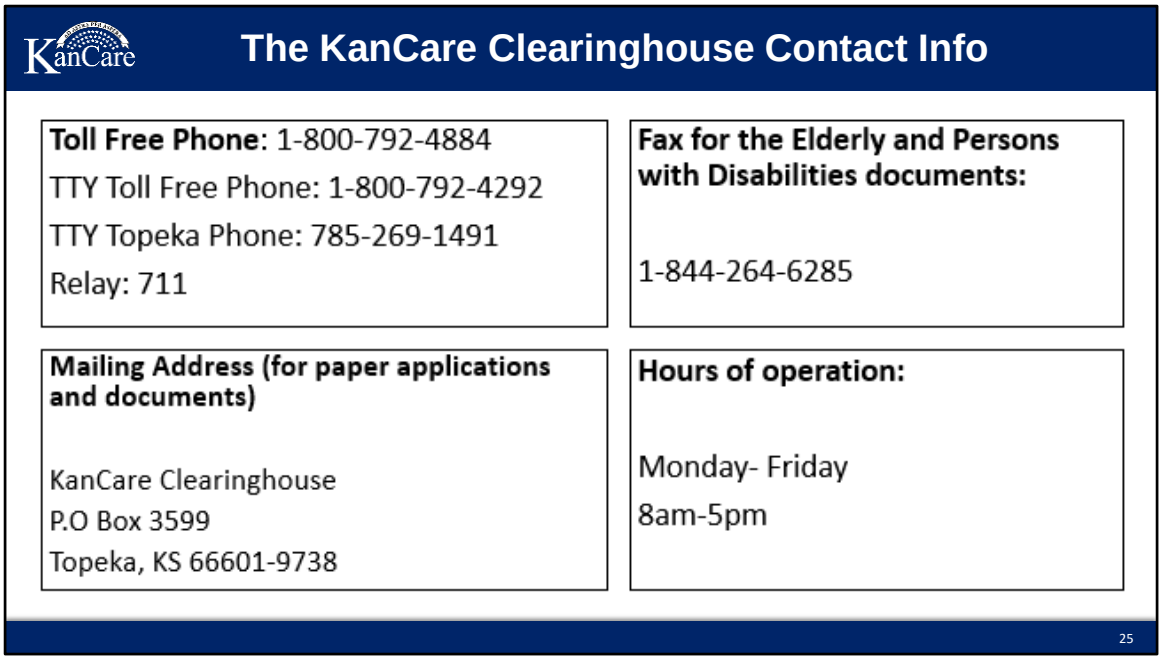
The KanCare Clearinghouse is the organization that the applicant can call for the following reasons and concerns:

- Reporting changes
- For questions about your application
- To check the status of your application
- To get the case number for your application
- To confirm documentation for application was received
- For problems with the application process
- For questions about moving to or from Kansas
- To close your Medicaid
- For questions about renewals
- To change the Responsible Party on your case
- To update your address or other information

- For adding a newborn baby to Medicaid
- Spenddown issues
- Client Obligation or Patient Liability issues

- This is not a complete list of possible reasons to contact the KanCare Clearinghouse

The KanCare Clearinghouse is where applications will be sent after they have been filled out to be processed for eligibility under the Medicaid programs. It is made up of several organizations that work together to run the Kansas Medicaid program. This will be important to know if applicants, Durable Power of Attorneys, Guardians, Conservators, Facilitators, and Medical Representatives have any questions about the application process or during the applicant's future KanCare coverage.



Here is the contact information for the KanCare Clearinghouse.

Call our Toll-Free Phone number to speak to a customer service agent. This number can be found throughout the application.

Our mailing address can be used to mail signed KanCare applications and any supporting documentation. Be sure to keep copies of the application and any documents sent.

Our fax number can be used to fax signed KanCare applications and any supporting documentation. Be sure to keep copies of the application and any documents sent.

Any documents sent to us at the KanCare Clearinghouse should have identifying information such as the first and last name, date of birth, or case number of the applicant. This will help us organize sent documents.

We are open from Monday through Friday, 8am to 5pm.

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This guide was created in partnership with the KanCare Ombudsman Office and the Kansas Department of Health and Environment.

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Thank you for looking at the KanCare Application Guide on filling out the Medicare Savings Program Only paper application.