



Application Supplement to KC1100

Who can use this supplement?	<p>This form is for applicants who have already filled out an application for families with children, but need help under our elderly and disabled medical programs.</p> <p>This form is not a valid application by itself.</p>
<p>On page 2 of this application you will be asked to indicate the type of help you want for each member of your household. The definition of each type of coverage is listed below. Please refer to these when answering.</p>	
Medically Needy (Spendedown)	<p>This program is for elderly and disabled persons who live in the community. Based on income level, some individuals are responsible for a portion of their medical expenses (spendedown) before coverage begins.</p>
Working Healthy	<p>This program is for disabled or blind persons between the ages of 16 to 64 who are working. Based on income level, some individuals are required to pay a monthly premium.</p>
Home and Community Based Services (HCBS)	<p>This program is for persons who have a medical need for services in the community (including in Assisted Living or Home Plus) which can keep them out of a nursing facility. There are currently 7 different HCBS programs, each with a different set of rules. Based on income level, some individuals are responsible for a portion of the cost of their care.</p>
Assisted Living	<p>Coverage is available for persons in assisted living through the HCBS Program.</p>
Nursing Home	<p>This category of coverage is for persons residing in a nursing home or similar facility (PRTF) for a long term stay (does not include Assisted Living). Based on income level, some individuals are responsible for a portion of the cost of their care in the facility.</p>
Program of All-Inclusive Care for the Elderly (PACE)	<p>This program is for disabled persons (age 55 years or older) and persons age 65 or older residing in selected counties within the state. Individuals receive long term care coverage through a managed care network. Based on income level, some individuals are responsible for a portion of the cost of their care.</p>
Medicare Savings Program (Medicare Costs)	<p>This program is for people who have Medicare and helps with some of the costs. This program pays the Part B premiums and may also pay Medicare co-payments and deductibles.</p>

Agency Use Only

Outstationed Worker

A. Tell us why you are applying
To help us better meet your needs, tell us why you are applying:

B. Tell us about the Primary Applicant:
The primary applicant is the person needing medical assistance.

Your Name: (First, Middle,Last)		Other names used:	
Home Address:		Mailing Address (If different)	
City:	State:	City:	State:
County:	Zip:	County:	Zip:

Check here if you don't have a home address. You still need to give a mailing address.

Home Phone: () —	Work Phone: () —
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C. Tell us about Yourself and the People in your home
List yourself and all persons in the household. Include those temporarily out of the home and those living in the home even if not applying for them. If you have more than 3 people in your home please attach another sheet of paper and send it with your application.

		Person 1 Yourself ↓	Person 2 ↓	Person 3 ↓
First Name				
Middle Name				
Last Name				
How is this person related to other household members?	Person 1 is my:	<i>Self – Person 1</i>		
	Person 2 is my:		<i>Self – Person 2</i>	
	Person 3 is my:			<i>Self – Person 3</i>
Is this person applying for medical assistance?		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what types of assistance does this person need? Check all that apply. (see page 1 for descriptions of programs)		<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (No Other Assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (No Other Assistance)	<input type="checkbox"/> Medically Needy <input type="checkbox"/> Working Healthy <input type="checkbox"/> HCBS <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home <input type="checkbox"/> PACE <input type="checkbox"/> Medicare Costs <input type="checkbox"/> Medicare Costs ONLY (No Other Assistance)

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Does this person need help paying medical bills from the last 3 months (including Medicare premiums)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, please see additional questions on page 4</i>			
Which of the following best describes this person's current living situation?	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility or other institution <input type="checkbox"/> Other	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility or other institution <input type="checkbox"/> Other	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility or other institution <input type="checkbox"/> Other
Is this person living outside of the home?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, why is this person living outside of the home?			
Date expected to return	/ /	/ /	/ /
If in a hospital, nursing facility or other institution, what is the name of the facility?			
Date Admitted	/ /	/ /	/ /
Date of Discharge	/ /	/ /	/ /
Have you ever been in a hospital or nursing facility for more than 30 days in a row?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when? (MM/DD/YY) through (MM/DD/YY)			
Has this person served in the military?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this person the spouse or widow of someone who served in the military?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what is this person's VA file number?			
Does this person pay for medical expenses? (including Medicare premiums)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
How much is the expense?	\$	\$	\$
How often?			
Describe the expense:			

D. Help with medical bills in the past 3 months	
Because you have requested help paying medical bills in the past 3 months, please answer these questions.	
Have there been any changes in the household during the last 3 months? (People moving in or out)	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the household changes:	
Have there been any changes in the household income during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the income changes:	
Have there been any changes in the household assets during the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, tell us about the asset changes:	

E. Tell Us if You Are Disabled			
We need to know if any persons in your household have a disability. Note: Personal Health Information disclosed here will only be used to determine your disability status and will not be shared with others. Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.			
	Person 1 Yourself ↓	Person 2 ↓	Person 3 ↓
First and Last Name			
Does this person have a disability that will last at least 12 months or result in death?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has this person ever applied for Social Security Benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Was the application denied?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when?			
Is the denial under appeal?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, what is the status?			
Has the existing condition become worse since the Social Security denial?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, explain			
Does this person have a new disability or condition that Social Security did not look at?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, briefly describe the disability.			
Is an attorney or someone else helping this person with the Social Security application for disability benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list name of the person and organization			
Phone number of person or organization			

F. Medicare Information

Answer the questions below for everyone who has Medicare.

	Person 1 Yourself ↓	Person 2 ↓	Person 3 ↓
Name			
Does this person have Medicare?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, answer the questions below.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicare Claim #			
Medicare Part A?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part A Effective Date	/ /	/ /	/ /
Part A Premium Amount	\$	\$	\$
Medicare Part B?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part B Effective Date	/ /	/ /	/ /
Part B Premium Amount	\$	\$	\$
Medicare Part C? (Medicare Advantage)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part C Effective Date	/ /	/ /	/ /
Part C Premium Amount	\$	\$	\$
Part C Plan Name			
Medicare Part D?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Part D Effective Date	/ /	/ /	/ /
Part D Premium Amount	\$	\$	\$
Part D Plan Name			

G. Tell us about your Work Expenses

If you are disabled and working, list any expenses related to your disability which allow you to work. Examples: specialized transportation to and from work, attendant care at work or to help you get ready for work, service animals, medications, specialized equipment or tools.

	Person 1 Yourself ↓		Person 2 ↓		Person 3 ↓	
Does this person have income from working?	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, list any expenses related to your disability which allows you to work.	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
		\$		\$		\$
		\$		\$		\$
		\$		\$		\$

H. Tell us about your Resources

We need to know about your resources to decide if you can get benefits. If you need more room, attach additional pages. Proof is required for all resources listed in this section.

1. Answer the questions below. Mark No or Yes on each item. If yes, provide details about the resource.

Type of Resource		Name(s) on Resource	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union, or Company)	Account Number
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Savings Account	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Certificate of Deposit (CD)	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Retirement Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Nursing Facility	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Accounts Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other:	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		
Other:	<input type="checkbox"/> No <input type="checkbox"/> Yes		\$		

2. Does anyone in your household have a vehicle? No Yes If yes, complete the following.

	Vehicle #1	Vehicle #2	Vehicle #3
Year			
Make			
Model			
Owner			
Estimated Value	\$	\$	\$
Balance Owed	\$	\$	\$
Registered in Kansas?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
How do you use the vehicle?			

3. Does anyone in your household have life insurance? No Yes If yes, complete the following. Include copies of all policies.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value
			\$	\$
			\$	\$
			\$	\$

4. Does anyone in your household own a home? No Yes If yes, complete the following.

Owners		Address			
Date Purchased	/ /	Value	\$	Amount Owed	\$
Who lives in the home?					
If the owner does not live there, explain why:					
If the owner does not live there, does the owner intend to return home?					<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, when?					

5. Does anyone in your household own other real estate (including buildings, lots, farm ground, second-homes)? No Yes If yes, complete the following.

Describe Property					
Is this property used as rental or income producing property?	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Owners		Address			
Date Purchased	/ /	Value	\$	Amount Owed	\$

6. Does anyone in your household have a life estate or life interest in any property?

No Yes If yes, complete the following.

Describe Property					
Owners		Address			
List date life estate created:	/ /	Value of Property	\$		

7. Does anyone in your household have a trust? No Yes If yes, complete the following.

Type		Owners		Amount	\$
Purpose					

8. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package? No Yes If yes, complete the following.

Owners		Value	\$		
Company					

Note: For Long Term Care assistance, the State of Kansas must be named as the beneficiary of any annuity you own which was purchased on or after February 8, 2006. More information will be given to you about this process. You agree to make this assignment when you sign the application.

9. Does anyone owe you money through a promissory note or other loans? No Yes

If yes, explain _____

10. Does anyone in your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc)? No Yes If yes, complete the following.

Describe Asset			
Owners		Value	\$
Describe Asset			
Owners		Value	\$

11. Have you or your spouse taken a loan against any property in the last five years, including a second mortgage or reverse mortgage? No Yes

12. Have you or your spouse ever waived rights to an inheritance or will? No Yes

13. Have you or your spouse ever worked with an attorney for Estate Planning purposes?
 No Yes If yes, complete the following.

Name of Attorney		Date	/	/
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14. Have you or your spouse sold, traded, given away or changed ownership of any property such as a house or money, or any other property in the last 5 years? No Yes If yes, complete the following.

Date Ownership Changed	Type of Property	Value	Given/Sold to	Purpose
/ /		\$		
/ /		\$		
/ /		\$		
/ /		\$		
/ /		\$		

I. Tell Us About Your Dependents and Household Expenses

Complete this section only if applying for HCBS or institutional care. You may be able to protect a portion or all of your own income for your dependents. If you have a spouse or minor child that is part of your household that you have not already told us about, go back to **Section C** and answer the questions.

Dependents					
If you have minor children that don't live with you or you have another family member who is dependent on you, please complete the following:					
Name of Individual	Relationship to you	Date of Birth	Individual's monthly income	If a child, who does the child live with?	If a child and living with another parent, list the monthly income of the parent
		/ /	\$		\$
		/ /	\$		\$
		/ /	\$		\$
Household Expense					
List monthly shelter expenses below for the spouse at home.					
Type of Expense			How Often?	Amount	
1	Rental Cost / Lot Rent			\$	
2	Mortgage Payment			\$	
3	Property Taxes (if not included in #2 above)			\$	
4	Home Insurance (if not included in #2 above)			\$	
5	Other (Condominium/Home Owners Association fees)			\$	

J. Choose Someone to Help You With Your Medical Assistance Case

Primary Applicant - If you are completing this application on behalf of someone for whom you are the Guardian, Conservator, Financial Power of Attorney or Social Security Payee, please complete the information below and submit proof.

First and Last Name				
Address Line 1				
Address Line 2				
City		State		Zip Code
Phone Number		Email Address		

You can name a person to help you with your medical assistance case. You can choose either a “Medical Representative” or a “Facilitator.”

Medical Representative is a person who can apply for you, talk about your case with KanCare, send in papers requested, and use your medical card for you. They will get copies of letters about your case. They have to send in your review each year and tell us about changes in your situation. Your Medical Representative can ask for a Fair Hearing or an appeal for you. They can also go with you to a hearing or represent you at the hearing. You can name a relative, neighbor, friend, or other person you trust to do this for you. They cannot be someone who is trying to collect a medical debt against you. This person will continue as your Medical Representative until you revoke them or appoint a different person.

Facilitator is a person or organization who can help you fill out your application and help you through the application process. You remain in charge of your case. We will be able to share information with this person. They will get copies of letters sent to you about your application. After your application is processed, they will no longer get any information about your case. But you have the option to allow sharing of information for up to one year. A facilitator can be a relative, neighbor, friend, medical office staff, or community organization employee. This person cannot make a request for coverage for you. * You have the option to tell us how long you want the information to be shared. This release will stay in effect for 6 months or until your application is completed, whichever is later. If you wish to provide a different date for this release indicate it here _____. An appointment of a community organization, a medical provider, or staff cannot exceed 12 months.

I want to appoint the following person to help me.

First and Last Name				
Organization Name				
Address Line 1				
Address Line 2				
City		State		Zip Code
Phone Number		Email Address		

What is this person's relationship to you? (for example: child, friend, neighbor, etc)

I appoint the above named person to be my Medical Representative, or Facilitator*.

Signature		Date	
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Witness signatures are required if the signature above is made with a mark.

Witness		Date	
Witness		Date	

K. 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 ask for a fair hearing if I do not agree with the decision made on my case. The request for an appeal must be made within 33 days from the date a notice of action is mailed by contacting KanCare or the Office of Administrative Hearings.

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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