

Case Number: [Added by staff]

Primary Applicant: [Added by staff]

We have received your application however we need some more information from you. Fill out this form and return it to us by [10 DAYS FROM MAILING].

You have told us that [INSERT NAME] is claimed as a tax dependent by [NAME/YOUR MOTHER/SOMEONE ELSE]. We need to know more information about this person and all other people listed on that tax return. Look at page 2 for more instructions.

Name of Person completing form:	Date:
If you need assistance in completing this form, call us at 1-800-792-4884.	

	Name	Date of Birth	SSN*	Relationship to [INSERT CASE NAME]	Does this person have income? If yes, send proof	If yes, what type? Examples: Wages, Social Security, Unemployment Compensation	What is the monthly amount of income?
Tax Filer #1	[INSERT TAX FILER NAME]	/ /			□No□Yes		\$
Tax Filer #2 If filing jointly		/ /			□ No □ Yes		\$
Dependent		/ /			☐ No ☐ Yes		\$
Dependent		/ /			□ No □ Yes		\$
Dependent		/ /			□ No □ Yes		\$
Dependent		/ /			□ No □ Yes		\$
Dependent		/ /			□No □Yes		\$

^{*}We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with medical assistance. If someone doesn't have a SSN, call 1-800-772-1213 or visit www.socialsecurity.gov

Proof of Income

We need proof of income for anyone listed on this form. Please send the following as proof.

- Working Send copies of their paystubs for the last month or a statement from their employer with their gross income and dates paid for the last month.
- **Self-employed** Send their most recent income tax return, with all pages and attachments.
- Other Income Send a copy of a check, benefit letter, court order, etc. that shows the amount of income they get and how often.

Return this Form

If you do not return this form along with proof of income, your request for medical assistance will be denied. Please return the form and income

information to: KanCare Clearinghouse

or

Fax to 1-800-498-1255

P.O. Box 3599

Topeka, KS 66601-9738

How to Fill Out This Form

Enter the name of the person who is filing taxes as Tax Filer #1. If this person files jointly, enter the spouse's name as Tax Filer #2. Enter the names of all other people on the tax return as Dependents. Then answer all questions for each person.

Example: Kurt is applying for medical assistance for himself and his child. Kurt doesn't live with his parents, Jane and Joe Smith, but they claim him as their tax dependent. They also claim Kurt's sister Katie as a tax dependent. Kurt does not have to list himself on this form because we already have his information. The example below shows how Kurt should fill out this form.

	Name	Date of Birth	SSN*	Relationship to Kurt	Does this person have income? If yes, send proof	If yes, what type? Examples: Wages, Social Security, Unemployment Compensation	What is the monthly amount of income?
Tax Filer #1	Jane Smith	10/15/68	111-11-1111	Mother	□ No XYes	Wages	\$ 2300
Tax Filer #2	Joe Smith	6/11/65	222-22-2222	Father	□ No XYes	Wages	\$ 1700
Dependent	Katie Smith	8/23/96	333-33-3333	Sister	X No □Yes		\$