Kansas Department of Health and Environment
Division of Health Care Finance

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KanCare

Facilitator Authorization Form

Consumer Name: _____

Consumer ID or SSN: _____

You can name a person to help you with your medical assistance case. This form is used to appoint a Facilitator.

A 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. You have the option to tell us how long you want the information to be shared (see below). This release will stay in effect until your application is completed. A facilitator can be a relative, neighbor, friend, medical office staff, or community organization employee.

They cannot make requests for coverage for you.

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, medical provider, community organization, etc.)					

I authorize the use or disclosure of my health information by the person named above to KDHE DHCF, DCF, and KDADS.
I understand that I have the right to revoke this authorization at any time by notifying KDHE DHCF.
I understand after this information is disclosed to a third party Federal law might not protect the information.
I understand that I am entitled to a copy of this authorization.
I understand that this authorization will expire 12 months from the date this form is signed or once my application is completed, whichever is later. Or you may provide a different date for the expiration of this release: _____.

My signature on this form signifies that I have read and understand the conditions above.

Signature: _____ Date: _____

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

Witness: _____ Date: _____

Witness: _____ Date: _____