Table of Contents

State/Territory Name: KS

State Plan Amendment (SPA) #: 14-0003-MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

December 9, 2014

Susan Mosier, MD, MBA, FACS
Executive Director
Kansas Department of Health and Environment
900 SW Jackson, Room 900N
Topeka, KS 66612

RE: S-94 – Eligibility Process State Plan Amendment (SPA), KS-14-0003-MM2

Dear Dr. Mosier:

Enclosed is an approved copy of Kansas' state plan amendment (SPA) KS-14-0003-MM2, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 27, 2014. SPA KS-14-0003-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Kansas' Medicaid state plan in accordance with the Affordable Care Act. This SPA was approved on December 8, 2014, with an effective date of January 1, 2014.

The approval of SPA KS-14-0003-MM2 includes full approval of your state's alternative single streamlined paper application. The state is using an interim alternative single streamlined online application and by October 31, 2015, will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of Kansas' approved state plan:

- S94, pages S94-1 and S94-2
- Attachment 1 – State of Kansas' alternative single streamlined paper application
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application

In addition, enclosed is a summary of state plan pages which are superseded by SPA KS-14-0003-MM2. This summary should be incorporated into a separate section in the front of the state plan.

- Superseding Pages of State Plan Material, KS-14-0003-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Karen Hatcher at (816) 426-5925.

Sincerely,

//s//

Leticia Barraza
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

cc: Bobbie Graff-Henderixon
Jeanine Schieferecke
Kim Tjelmeland

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

December 9, 2014

Susan Mosier, MD, MBA, FACS
Executive Director
Kansas Department of Health and Environment
900 SW Jackson, Room 900N
Topeka, KS 66612

RE: S-94 – Eligibility Process State Plan Amendment (SPA), KS-14-0003-MM2

Dear Dr. Mosier:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) transmittal KS-14-0003-MM2. Our review of this submission included a review of the online alternative single streamlined application developed by the state.

Until October 31, 2015, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

MAGI-based Online Application Necessary Changes	**Completion Date**
The state agrees to add logic to ask questions about access to employer sponsored coverage only for applicants who appear ineligible for Medicaid and CHIP.	October 31, 2015
Pensions and retirement income is generally taxable and should be included as a MAGI income type rather than a non-MAGI income type.	June 30, 2015

Please submit the revised alternative single streamline online application to CMS for review no later than October 1, 2015 to ensure approval by October 31, 2015. We continue to be available to provide technical assistance.

If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (415) 744-3860. If you have any questions concerning this SPA, please contact Karen Hatcher at Karen.Hatcher@cms.hhs.gov or (816) 426-5925.

Sincerely,

//s//

Leticia Barraza
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

cc: Bobbie Graff-Henderixon
Jeanine Schieferecke
Kim Tjelmeland

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

November 18, 2015

Susan Mosier, M.D. MBS, FACS
Executive Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900N
Topeka, KS 66612

Dear Dr. Mosier:

On December 9, 2014, the Centers for Medicare & Medicaid Services (CMS) approved Kansas' State Plan Amendment (SPA) 14-0003-MM2 with an effective date of January 1, 2014. This SPA included approval for the State to use an interim alternative single streamlined online application.

The CMS has reviewed the changes submitted with respect to Kansas' alternative single streamlined online application. The revised application addresses the concerns outlined in the companion letter that was issued with the SPA approval. This letter serves as official approval of Kansas' alternative single streamlined online application with an approval date of November 9, 2015, and an effective date of September 28, 2015.

Enclosed is a copy of the approved alternative single streamlined online application. Please incorporate these pages into the State Plan following the attachment to S94 entitled "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact Karen Hatcher at (816) 426-5925 or Karen.Hatcher@cms.hhs.gov.

Sincerely,

//s//

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc: Mike Randol
Bobbie Graff-Hendrixson
Jeanine Schieferecke
Kim Tjelmeland

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Kansas**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

KS-14-0003

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

The fiscal impact does not include Administrative costs. This is the MAGI Eligibility Amendment.

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Bobbie Graff-Hendrixson**
Last Revision Date:	**Nov 14, 2014**
Submit Date:	**Mar 27, 2014**

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: KS 14-0003-MM2	**STATE:** Kansas
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN 91-41 Effective date: 10/1/91, approved: 1/27/92 Section 2, Page 11a, section 2.1(d), TN 91-47 Effective date: 10/1/91 , approved: 2/19/92

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	FAX	Facsimile Machine	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

☐ Paper Application ☒ Online Application

TRANSMITTAL NUMBER:	**STATE:**
KS-14-0003-MM2	Kansas

Through October 31, 2015, the state is using an interim alternative single streamlined application. After October 31, 2015, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

State of Kansas

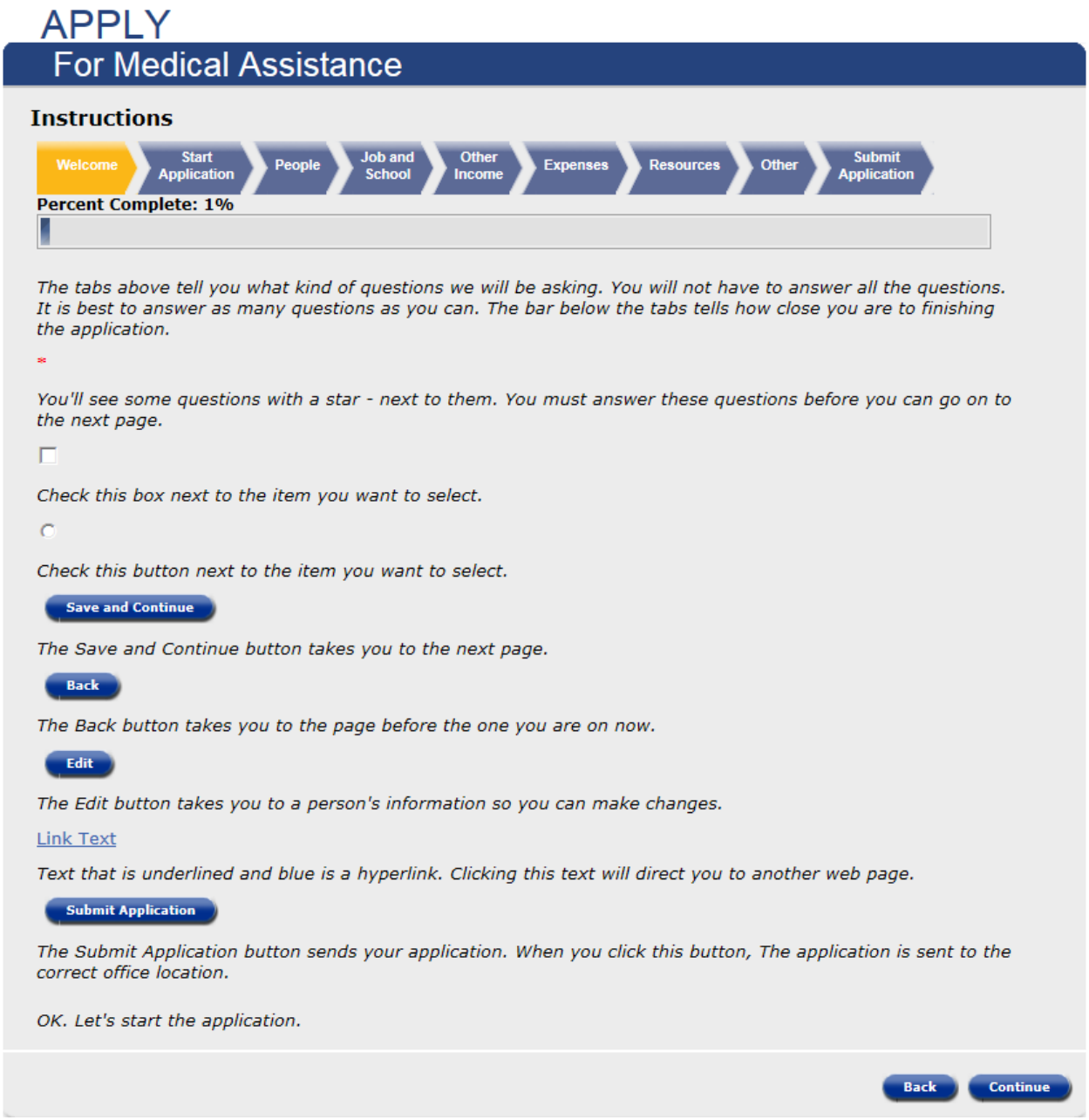
Online Medical Application

Application Version -October 2015

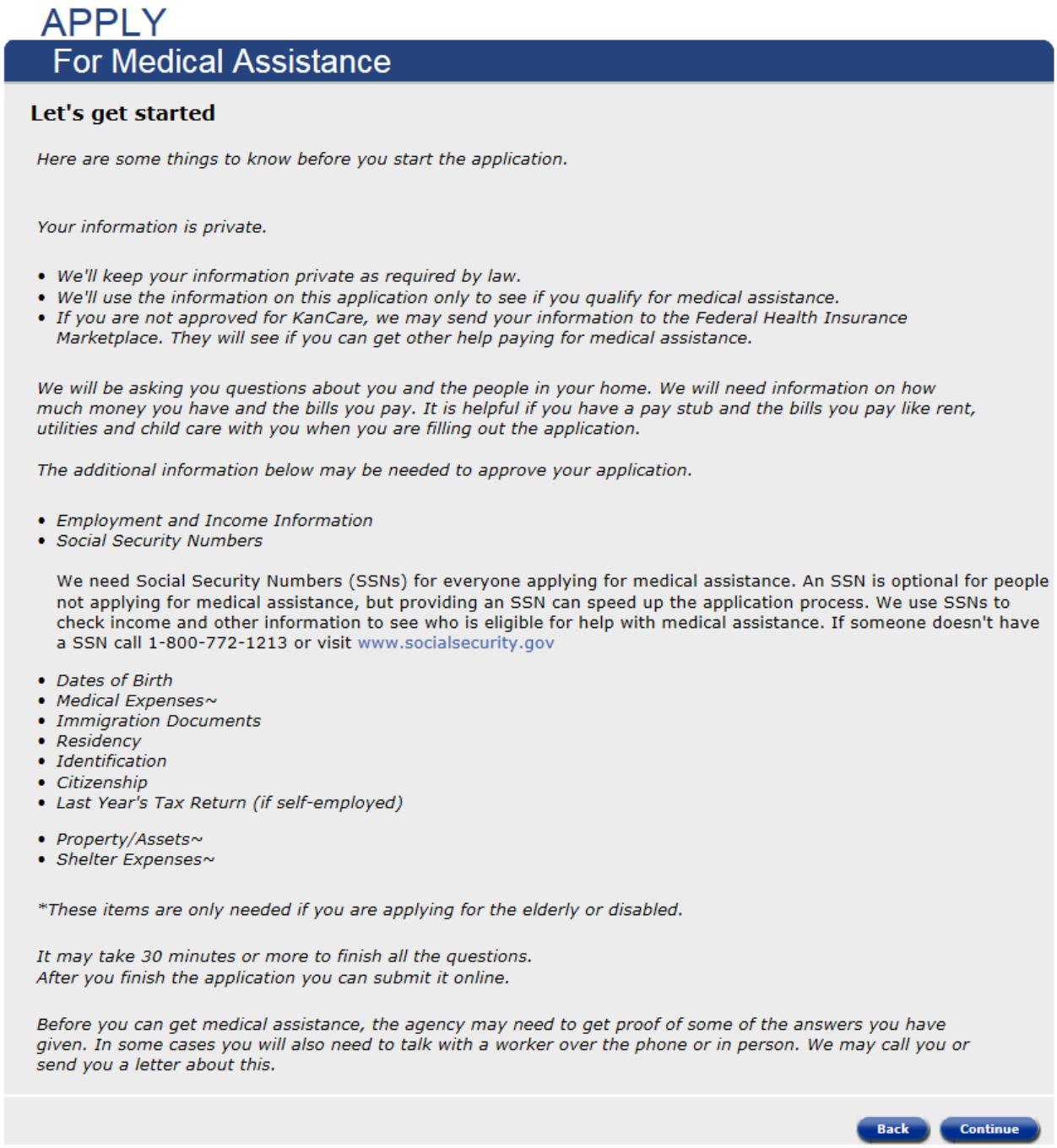
Date of Document – 09-23-15

Contents

Welcome


APPLY
For Medical Assistance
Instructions
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 1%
The tabs above tell you what kind of questions we will be asking. You will not have to answer all the questions. It is best to answer as many questions as you can. The bar below the tabs tells how close you are to finishing the application.
*
You'll see some questions with a star - next to them. You must answer these questions before you can go on to the next page.
Check this box next to the item you want to select.
Check this button next to the item you want to select.
Save and Continue
The Save and Continue button takes you to the next page.
Back
The Back button takes you to the page before the one you are on now.
Edit
The Edit button takes you to a person's information so you can make changes.
Link Text
Text that is underlined and blue is a hyperlink. Clicking this text will direct you to another web page.
Submit Application
The Submit Application button sends your application. When you click this button, The application is sent to the correct office location.
OK. Let's start the application.
Back
Continue

Let's Get Started



APPLY

For Medical Assistance

Let's get started

Here are some things to know before you start the application.

Your information is private.

- *We'll keep your information private as required by law.*
- *We'll use the information on this application only to see if you qualify for medical assistance.*
- *If you are not approved for KanCare, we may send your information to the Federal Health Insurance Marketplace. They will see if you can get other help paying for medical assistance.*

We will be asking you questions about you and the people in your home. We will need information on how much money you have and the bills you pay. It is helpful if you have a pay stub and the bills you pay like rent, utilities and child care with you when you are filling out the application.

The additional information below may be needed to approve your application.

- *Employment and Income Information*
- *Social Security Numbers*

We need Social Security Numbers (SSNs) for everyone applying for medical assistance. An SSN is optional for people not applying for medical assistance, but providing an 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

- *Dates of Birth*
- *Medical Expenses~*
- *Immigration Documents*
- *Residency*
- *Identification*
- *Citizenship*
- *Last Year's Tax Return (if self-employed)*

- *Property/Assets~*
- *Shelter Expenses~*

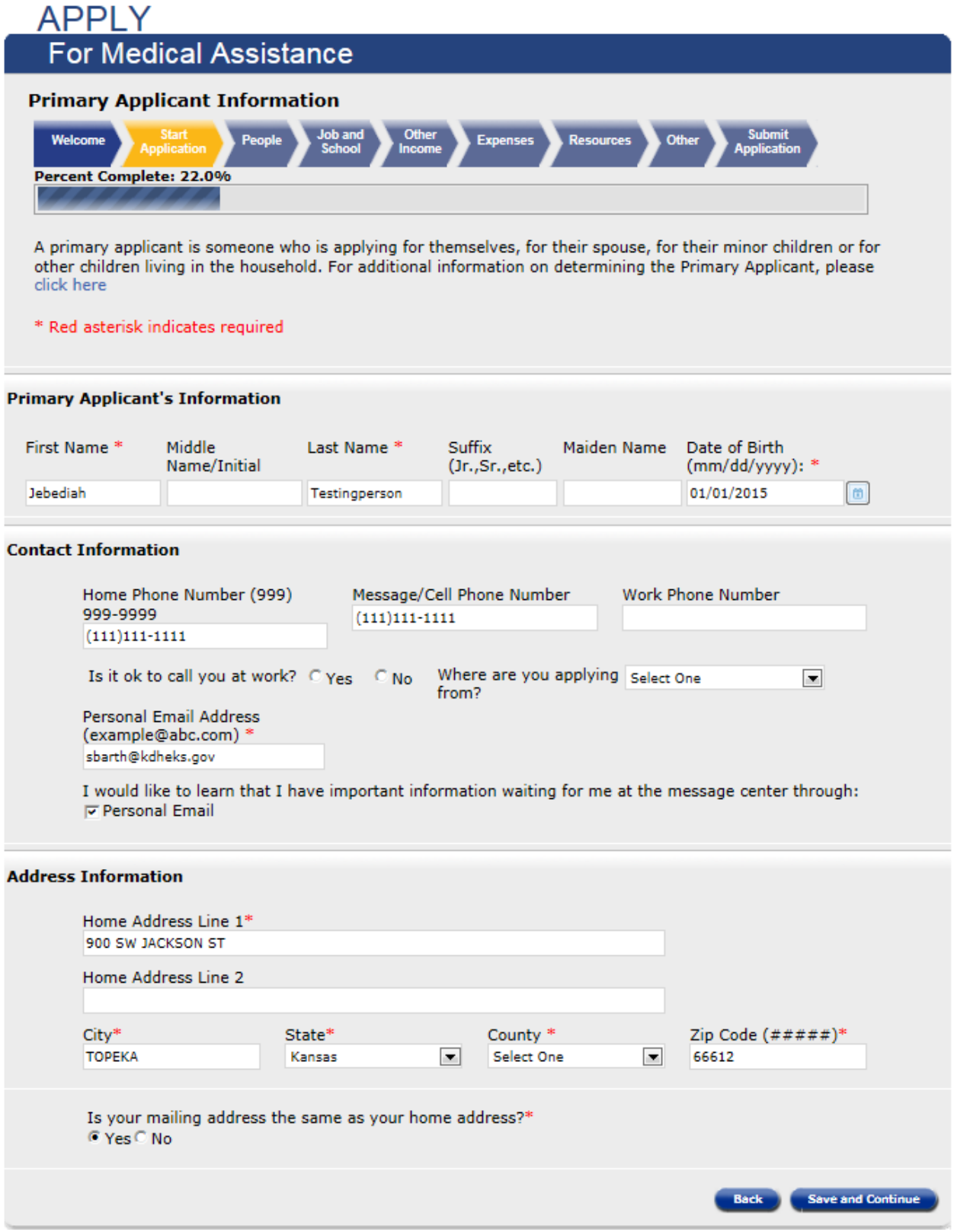
**These items are only needed if you are applying for the elderly or disabled.*

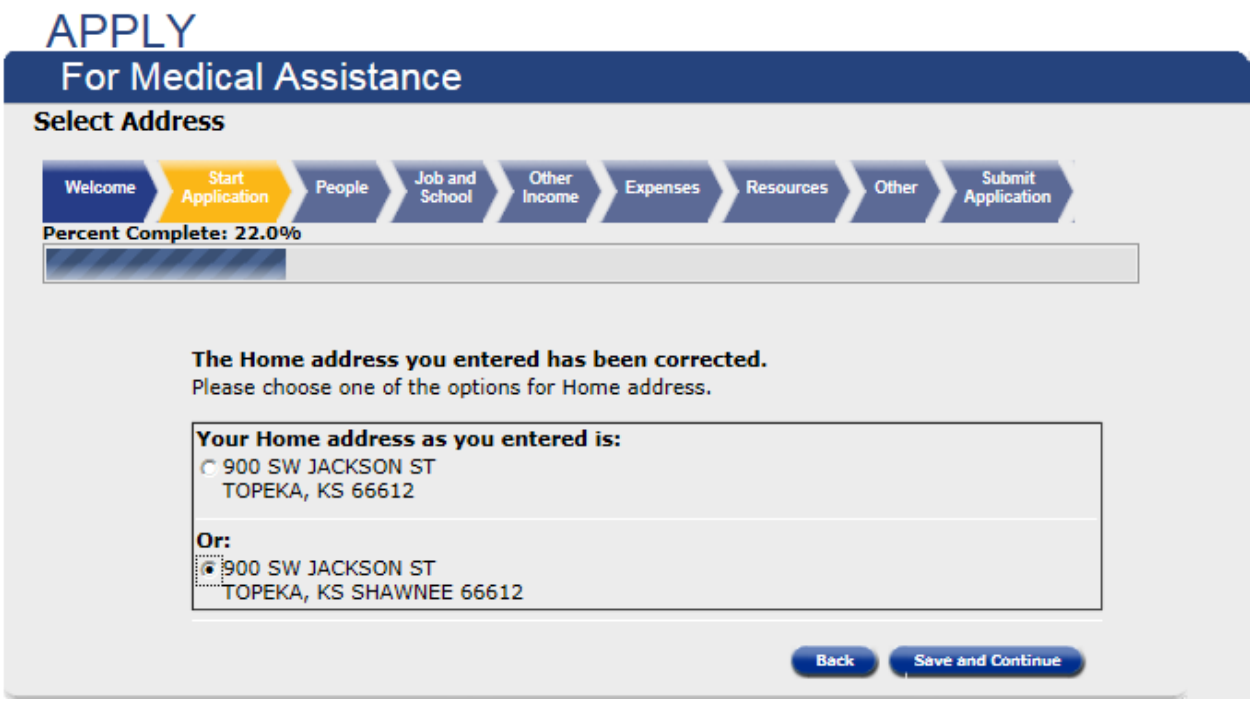
It may take 30 minutes or more to finish all the questions.
After you finish the application you can submit it online.

Before you can get medical assistance, the agency may need to get proof of some of the answers you have given. In some cases you will also need to talk with a worker over the phone or in person. We may call you or send you a letter about this.

Back Continue

Start Application




APPLY
For Medical Assistance
Select Address
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 22.0%
The Home address you entered has been corrected.
Please choose one of the options for Home address.
Your Home address as you entered is:
900 SW JACKSON ST
TOPEKA, KS 66612
Or:
900 SW JACKSON ST
TOPEKA, KS SHAWNEE 66612
Back
Save and Continue


APPLY
For Medical Assistance
Tell us More
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 22.0%
Please tell us more about yourself.
Jebediah Testingperson
Are you applying for yourself?*
Yes No
Are you male or female?*
Male Female
Social Security Number (i.e.123-45-6789):
111-11-1111
Marital Status:
Married
Do any of the following apply to you?
Yes No
You are 65 or older, or will turn 65 in the next 2 months
You have a disability that will last at least 12 months or result in death
You need help with nursing home care, home health care, institutional care or other long term care.
Are you known by another name?
Yes No
Do you need help paying medical bills from the last 3 months?
Yes No
Back
Save and Continue

APPLY

For Medical Assistance

Background Information

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 22.0%

Please tell us more about yourself.

Jebediah Testingperson

What language do you speak at home?	English
What language do you read at home?	English
Do you have other communication needs?	Select One
What is your race? (optional) Check all that apply.	☑ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander
Are you Hispanic, Latino/a or Spanish origin? (optional) Check all that apply.	☑ No, not of Hispanic, Latino/a or Spanish origin ☐ Yes, Mexican, Mexican American or Chicano/a ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a or Spanish origin
What is your U.S. citizenship or non-citizen status:*	US Citizen

Back | Save and Continue

APPLY

For Medical Assistance

Start Application Summary

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 22.0%

Show All | Hide All

Tell us More

Jebediah Testingperson — Hide Details

Are you applying for yourself?*	Yes
Are you male or female?*	Male
Social Security Number (i.e.123-45-6789):	111-11-1111
Marital Status:	Married
Do any of the following apply to you? • You are 65 or older, or will turn 65 in the next 2 months • You have a disability that will last at least 12 months or result in death • You need help with nursing home care, home health care, institutional care or other long term care.	No
Are you known by another name?	No
Do you need help paying medical bills from the last 3 months?	No

Edit

Background Information

Jebediah Testingperson — Hide Details

What language do you speak at home?	English
What language do you read at home?	English
Do you have other communication needs?	
What is your race? (optional) Check all that apply.	White
Are you Hispanic, Latino/a or Spanish origin? (optional) Check all that apply.	No, not of Hispanic, Latino/a or Spanish origin
What is your U.S. citizenship or non-citizen status:*	US Citizen

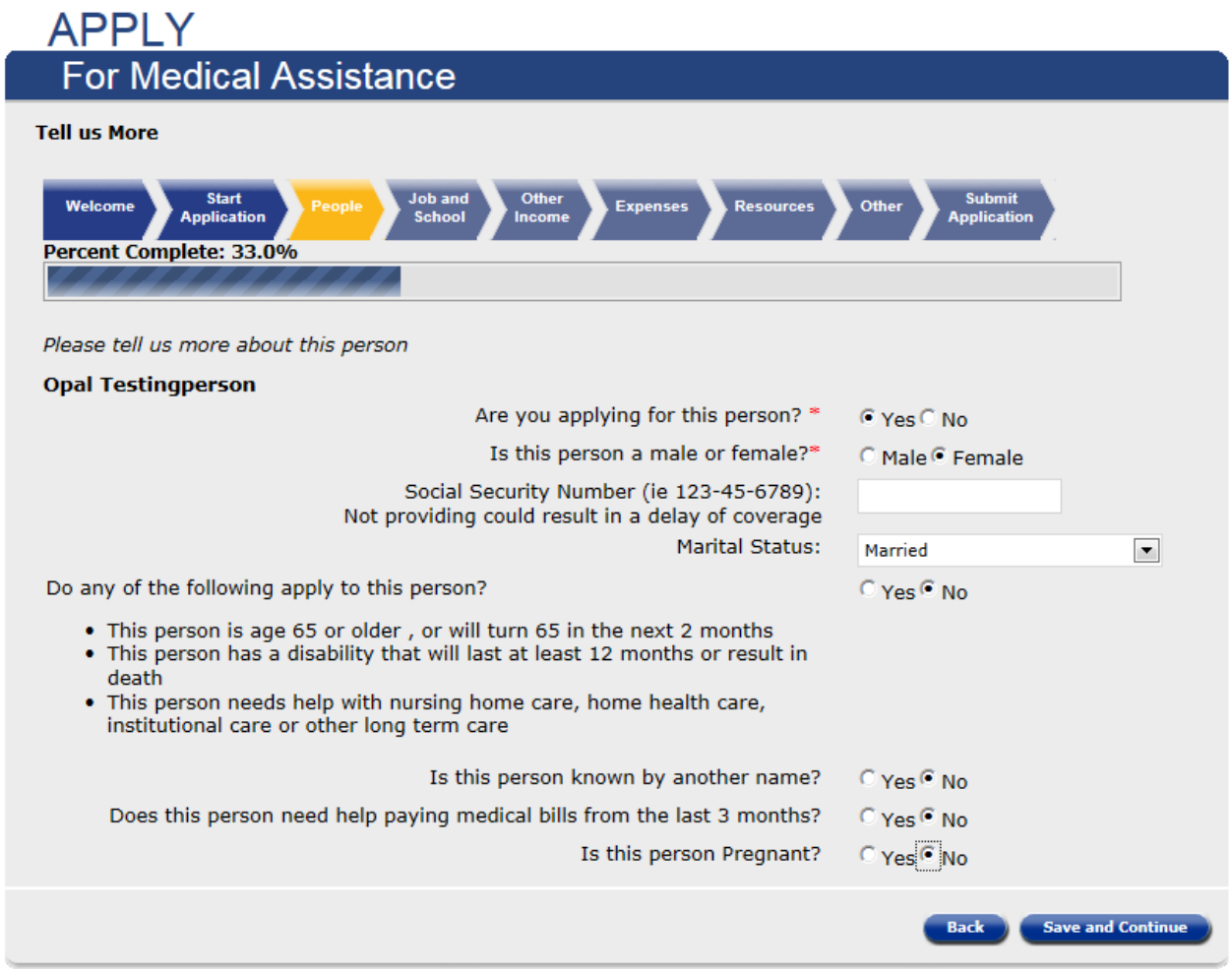
Edit

Save and Exit | Save and Continue

People


APPLY
For Medical Assistance
Information about the people living in your home
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
Primary Applicant
Jebediah Testingperson
Is anyone else in your home?
Add Another Person
Save and Exit
Save and Continue


APPLY
For Medical Assistance
Information about the people living in your home
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
Please tell us about everyone living in your home. Include anyone that lives with you – even if they do not need coverage.
First Name:*
Opal
Middle Name/Initial:
Last Name:*
Testingperson
Suffix:
Maiden Name:
Date of Birth(mm/dd/yyyy):*
02/02/1972
Does this person live at the same address as you?
Yes
No
Back
Save and Continue


APPLY
For Medical Assistance
Tell us More
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
Please tell us more about this person
Opal Testingperson
Are you applying for this person? *
Yes No
Is this person a male or female?*
Male Female
Social Security Number (ie 123-45-6789):
Not providing could result in a delay of coverage
Marital Status:
Married
Do any of the following apply to this person?
Yes No
This person is age 65 or older , or will turn 65 in the next 2 months
This person has a disability that will last at least 12 months or result in death
This person needs help with nursing home care, home health care, institutional care or other long term care
Is this person known by another name?
Yes No
Does this person need help paying medical bills from the last 3 months?
Yes No
Is this person Pregnant?
Yes No
Back
Save and Continue

APPLY

For Medical Assistance

Background Information

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 33.0%

Please give us additional information about this person

Opal Testingperson

What is this person's race? Check all that apply. (Optional)

- [x] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Other Asian
- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Other Pacific Islander

Is this person Hispanic, Latino/a or Spanish origin? Check all that apply. (Optional)

- [x] No, not of Hispanic, Latino/a or Spanish origin
- [ ] Yes, Mexican, Mexican American or Chicano/a
- [ ] Yes, Puerto Rican
- [ ] Yes, Cuban
- [ ] Yes, another Hispanic, Latino/a or Spanish origin

What is this person's U.S. citizenship or non-citizen status:* Lawful Permanent Resident (LPR)

Has this person delivered a baby in the last 3 months? ( ) Yes ( ) No

Did this person have emergency care in the last 3 months to save life, organs, or bodily function? ( ) Yes ( ) No

Choose this person's document type:* I-551 (Permanent Resident Card)

Enter the information as it appears on your document. Not providing this information could result in a delay of coverage.

First Name (as it appears on document): Opal

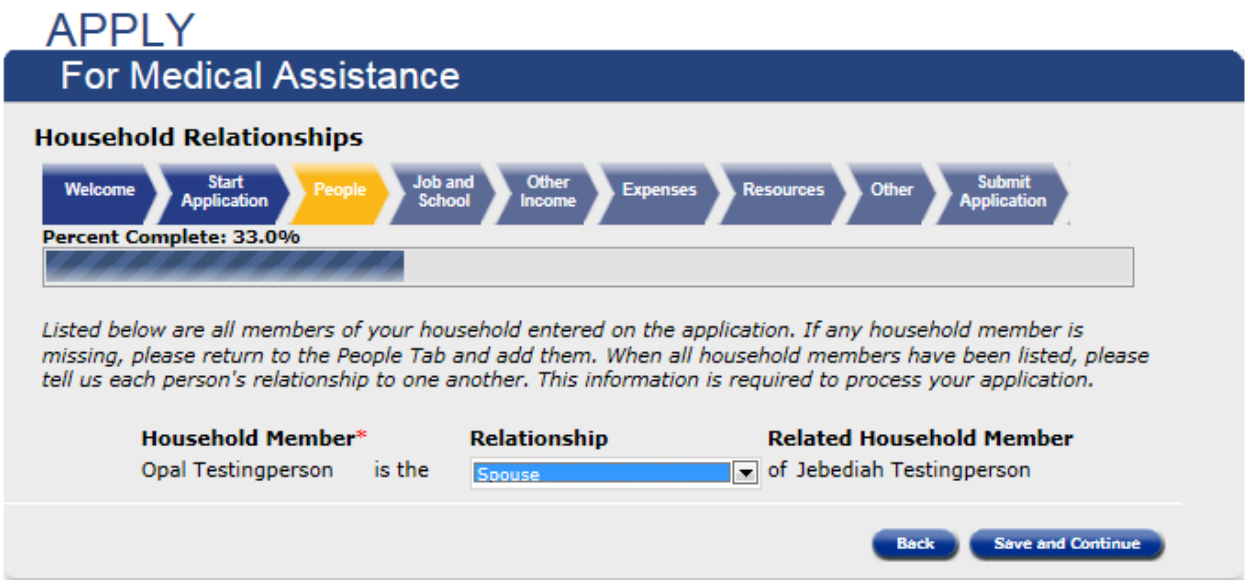
Middle Name (as it appears on document):

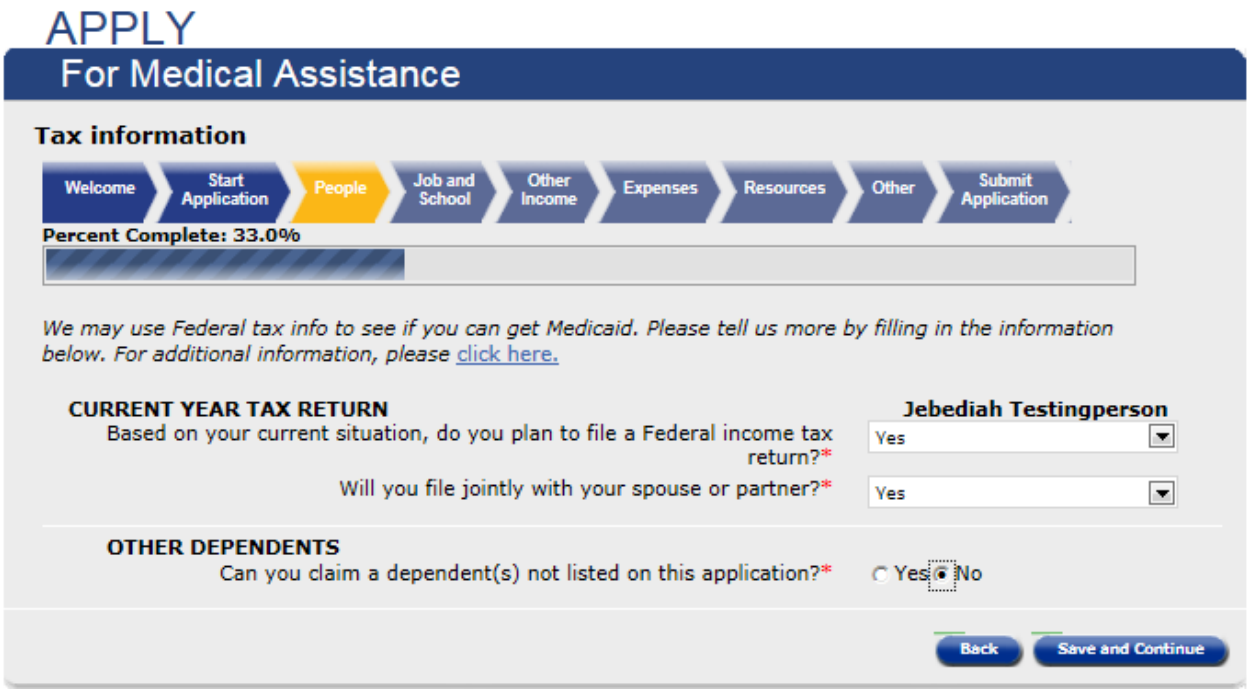
Last Name (as it appears on document): Testingperson

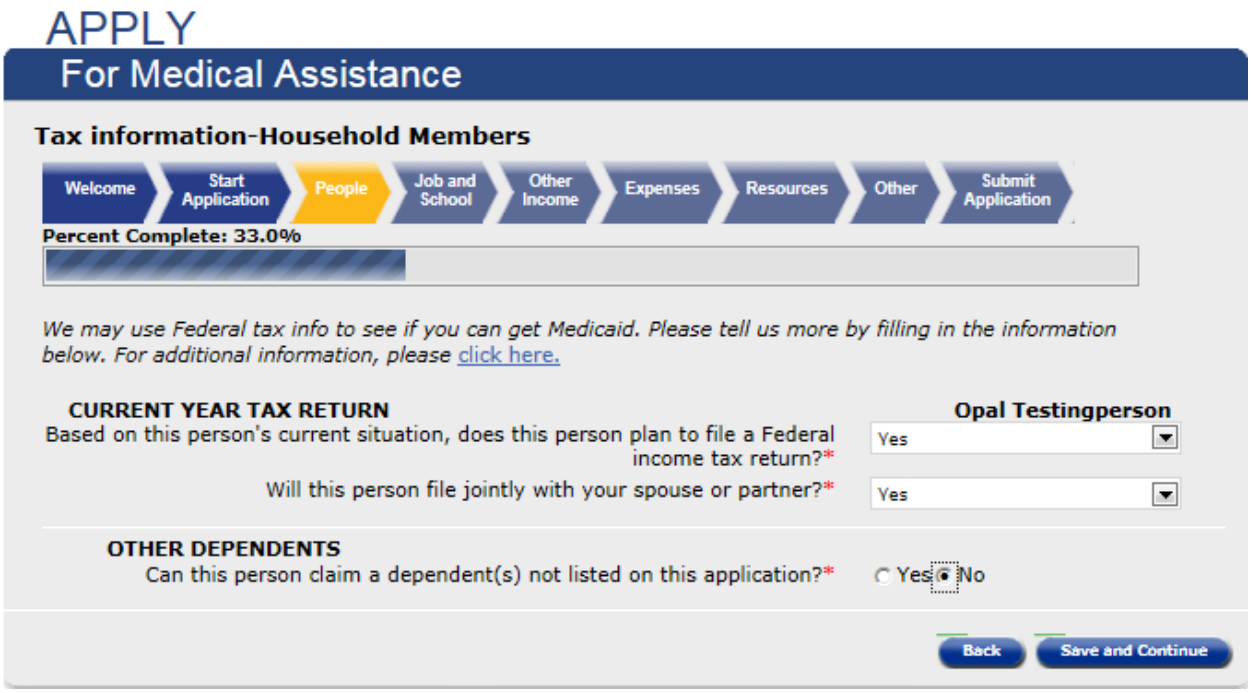
Date of Birth (as it appears on document): 02/02/1972

Alien Number: 222222-22

Back | Save and Continue


APPLY
For Medical Assistance
Household Relationships
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
Listed below are all members of your household entered on the application. If any household member is missing, please return to the People Tab and add them. When all household members have been listed, please tell us each person's relationship to one another. This information is required to process your application.
Household Member*
Relationship
Related Household Member
Opal Testingperson
is the
Spouse
of Jebediah Testingperson
Back
Save and Continue


APPLY
For Medical Assistance
Tax information
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
We may use Federal tax info to see if you can get Medicaid. Please tell us more by filling in the information below. For additional information, please click here.
CURRENT YEAR TAX RETURN
Jebediah Testingperson
Based on your current situation, do you plan to file a Federal income tax return?*
Yes
Will you file jointly with your spouse or partner?*
Yes
OTHER DEPENDENTS
Can you claim a dependent(s) not listed on this application?*
Yes
No
Back
Save and Continue


APPLY
For Medical Assistance
Tax information-Household Members
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
We may use Federal tax info to see if you can get Medicaid. Please tell us more by filling in the information below. For additional information, please click here.
CURRENT YEAR TAX RETURN
Opal Testingperson
Based on this person's current situation, does this person plan to file a Federal income tax return?*
Yes
Will this person file jointly with your spouse or partner?*
Yes
OTHER DEPENDENTS
Can this person claim a dependent(s) not listed on this application?*
Yes
No
Back
Save and Continue

APPLY

For Medical Assistance

Information about the people living in your home

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 33.0%

Primary Applicant	Jebediah Testingperson
Household Members	Opal Testingperson

Show All | Hide All

Opal Testingperson

Information about the people living in your home — Hide Details

First Name:*	Opal
Middle Name/Initial:	
Last Name:*	Testingperson
Suffix:	
Maiden Name:	
Date of Birth(mm/dd/yyyy):*	02/02/1972
Does this person live at the same address as you?	Yes

Edit

Tell us More — Hide Details

Are you applying for this person? *	Yes
Is this person a male or female?*	Female
Social Security Number (ie 123-45-6789): Not providing could result in a delay of coverage	
Marital Status:	Married
Do any of the following apply to this person?	No

- This person is age 65 or older , or will turn 65 in the next 2 months
- This person has a disability that will last at least 12 months or result in death
- This person needs help with nursing home care, home health care, institutional care or other long term care

Is this person known by another name?	No
Does this person need help paying medical bills from the last 3 months?	No
Is this person Pregnant?	No

Edit

Background Information — Hide Details

What is this person's race? Check all that apply. (Optional)	White
Is this person Hispanic, Latino/a or Spanish origin? Check all that apply. (Optional)	No, not of Hispanic, Latino/a or Spanish origin
What is this person's U.S. citizenship or non-citizen status:*	Lawful Permanent Resident (LPR)
Has this person delivered a baby in the last 3 months?	
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	
Choose this person's document type:*	I-551 (Permanent Resident Card)

Enter the information as it appears on your document. Not providing this information could result in a delay of coverage.

First Name (as it appears on document):	Opal
Middle Name (as it appears on document):	
Last Name (as it appears on document):	Testingperson
Date of Birth (as it appears on document):	02/02/1972
Alien Number:	222222-22

Edit

Delete Person

Is anyone else in your home? Add Another Person

Save and Exit | Save and Continue

APPLY

For Medical Assistance

Information about the people living in your home

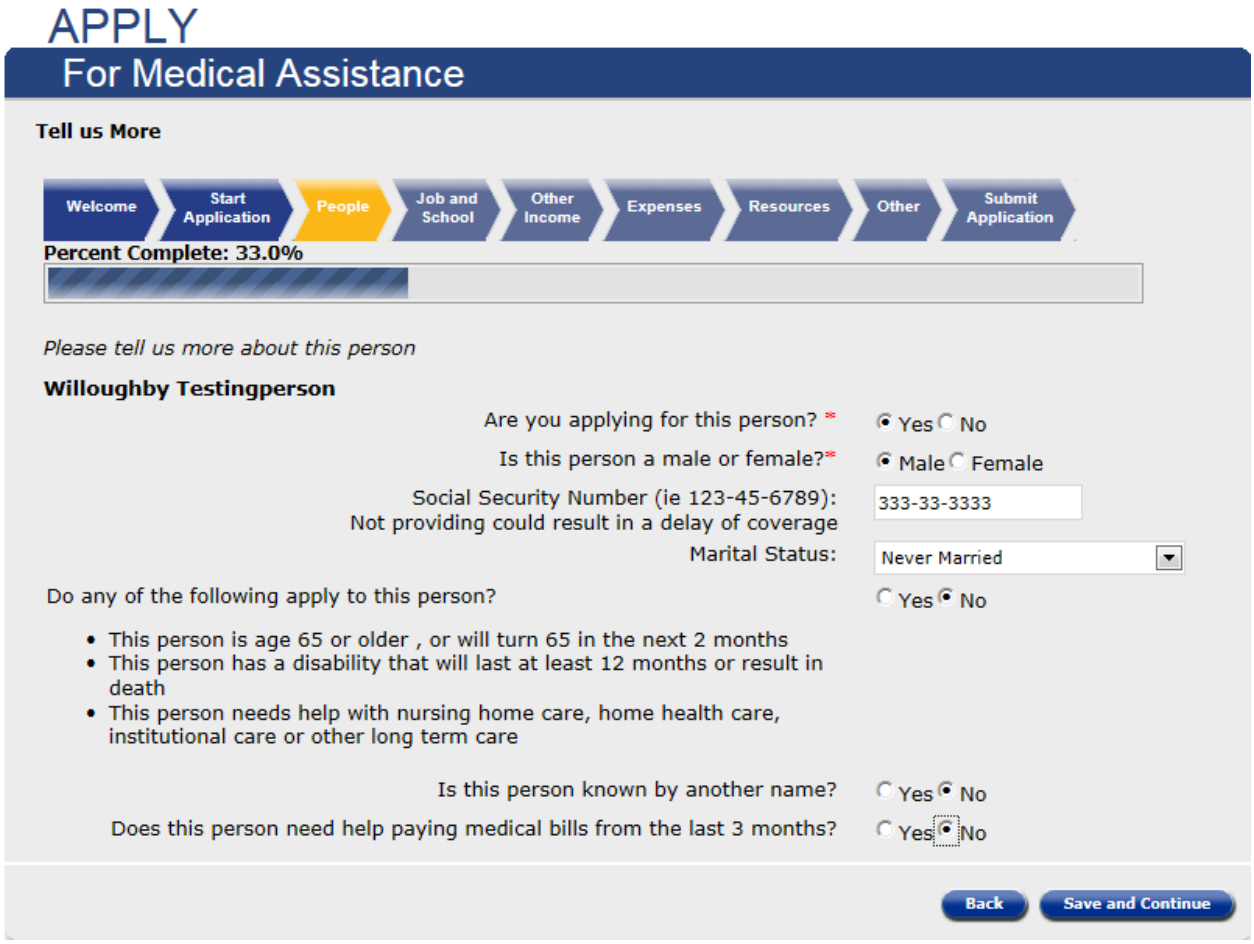
Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 33.0%

Please tell us about everyone living in your home. Include anyone that lives with you – even if they do not need coverage.

First Name:*	Willoughby
Middle Name/Initial:	
Last Name:*	Testingperson
Suffix:	
Maiden Name:	
Date of Birth(mm/dd/yyyy):*	03/03/2013
Does this person live at the same address as you?	(•) Yes ( ) No

Back | Save and Continue


APPLY
For Medical Assistance
Tell us More
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
Please tell us more about this person
Willoughby Testingperson
Are you applying for this person? *
Yes No
Is this person a male or female?*
Male Female
Social Security Number (ie 123-45-6789):
Not providing could result in a delay of coverage
333-33-3333
Marital Status:
Never Married
Do any of the following apply to this person?
Yes No
This person is age 65 or older , or will turn 65 in the next 2 months
This person has a disability that will last at least 12 months or result in death
This person needs help with nursing home care, home health care, institutional care or other long term care
Is this person known by another name?
Yes No
Does this person need help paying medical bills from the last 3 months?
Yes No
Back
Save and Continue

APPLY

For Medical Assistance

Background Information

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 33.0%

Please give us additional information about this person

Willoughby Testingperson

What is this person's race? Check all that apply. (Optional)

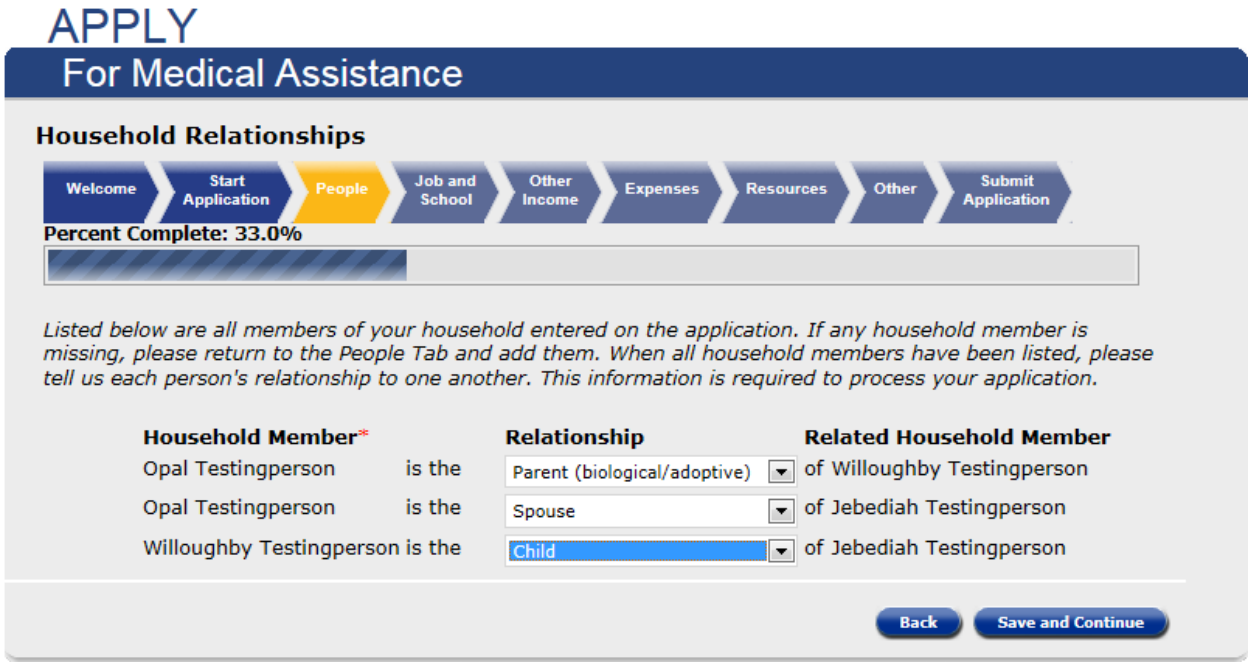
- [x] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Other Asian
- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Other Pacific Islander

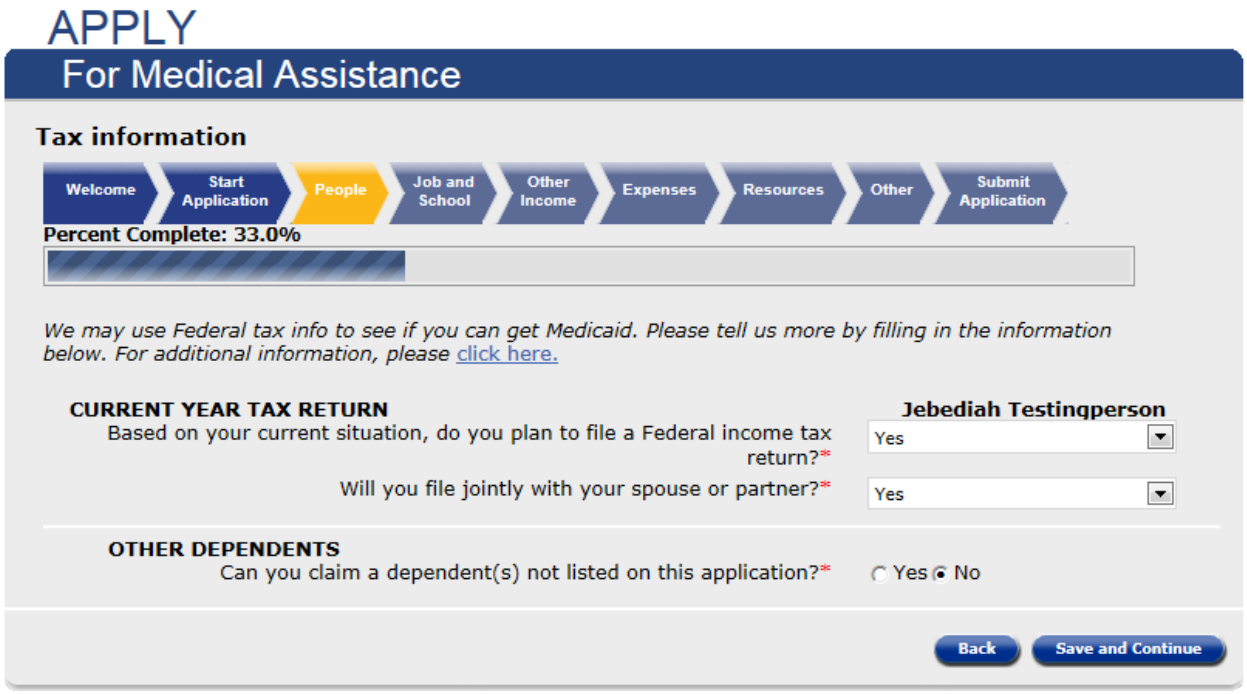
Is this person Hispanic, Latino/a or Spanish origin? Check all that apply. (Optional)

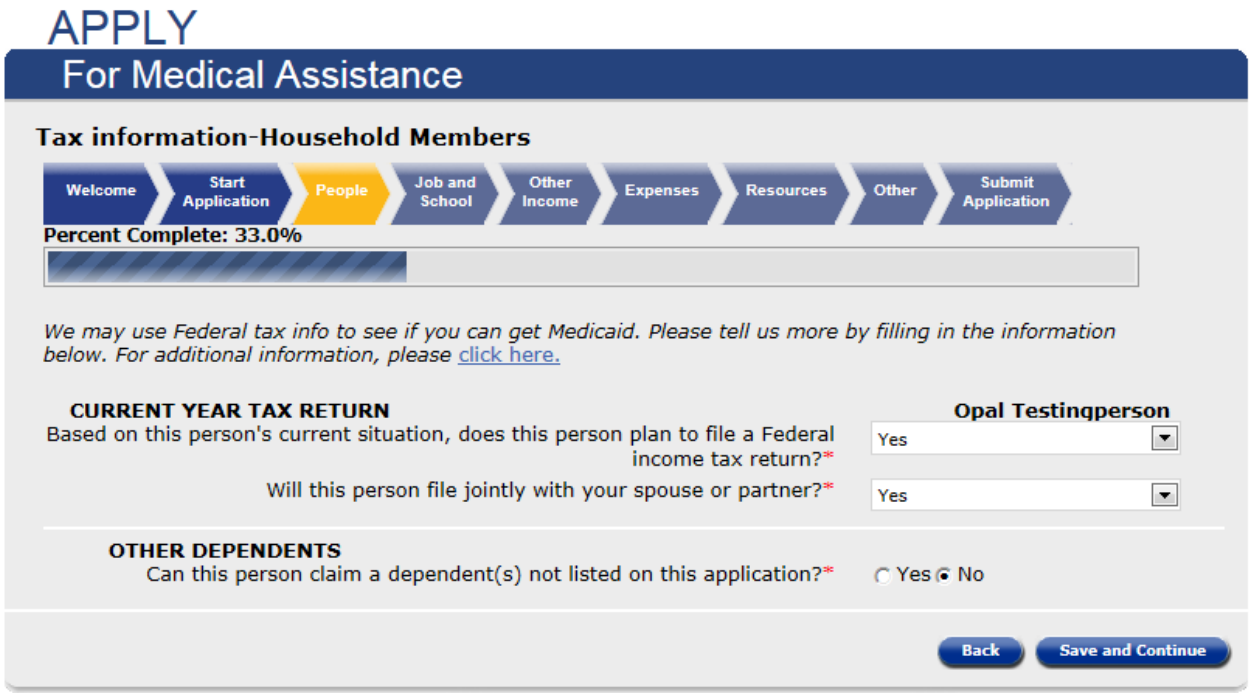
- [x] No, not of Hispanic, Latino/a or Spanish origin
- [ ] Yes, Mexican, Mexican American or Chicano/a
- [ ] Yes, Puerto Rican
- [ ] Yes, Cuban
- [ ] Yes, another Hispanic, Latino/a or Spanish origin

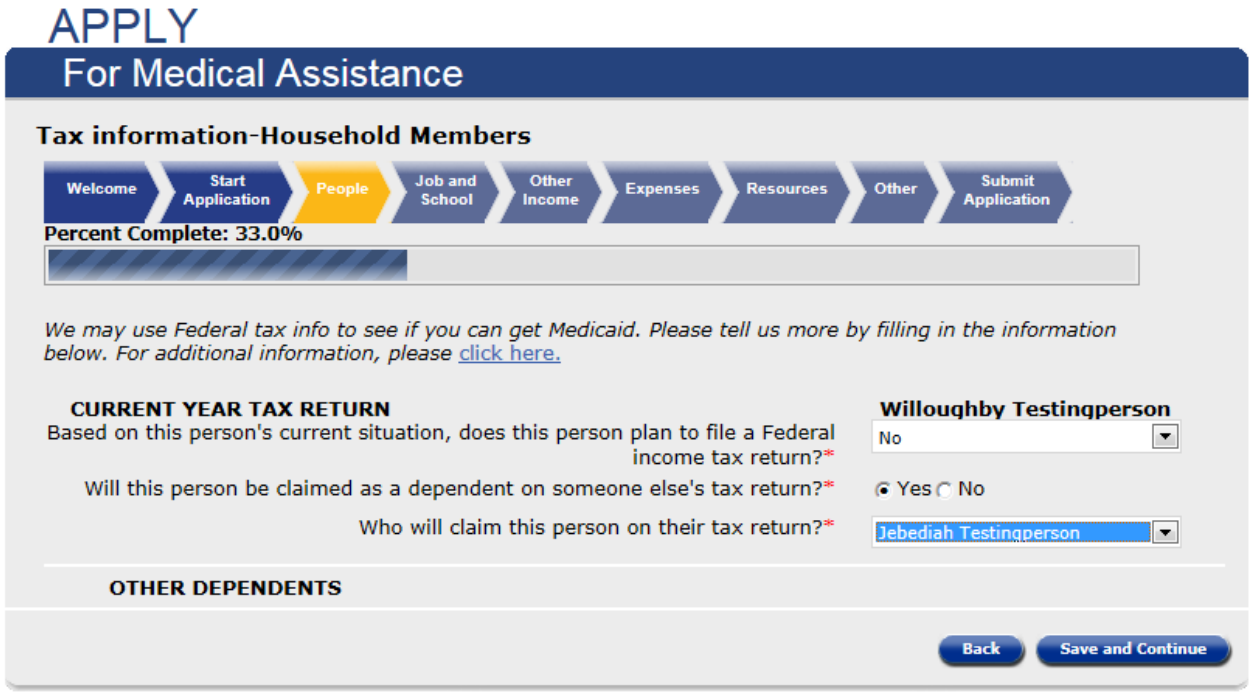
What is this person's U.S. citizenship or non-citizen status:* US Citizen

Back | Save and Continue


APPLY
For Medical Assistance
Household Relationships
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
Listed below are all members of your household entered on the application. If any household member is missing, please return to the People Tab and add them. When all household members have been listed, please tell us each person's relationship to one another. This information is required to process your application.
Household Member*
Relationship
Related Household Member
Opal Testingperson is the Parent (biological/adoptive) of Willoughby Testingperson
Opal Testingperson is the Spouse of Jebediah Testingperson
Willoughby Testingperson is the Child of Jebediah Testingperson
Back
Save and Continue


APPLY
For Medical Assistance
Tax information
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
We may use Federal tax info to see if you can get Medicaid. Please tell us more by filling in the information below. For additional information, please click here.
CURRENT YEAR TAX RETURN
Jebediah Testingperson
Based on your current situation, do you plan to file a Federal income tax return?*
Yes
Will you file jointly with your spouse or partner?*
Yes
OTHER DEPENDENTS
Can you claim a dependent(s) not listed on this application?*
Yes
No
Back
Save and Continue


APPLY
For Medical Assistance
Tax information-Household Members
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
We may use Federal tax info to see if you can get Medicaid. Please tell us more by filling in the information below. For additional information, please click here.
CURRENT YEAR TAX RETURN
Opal Testingperson
Based on this person's current situation, does this person plan to file a Federal income tax return?*
Yes
Will this person file jointly with your spouse or partner?*
Yes
OTHER DEPENDENTS
Can this person claim a dependent(s) not listed on this application?*
Yes
No
Back
Save and Continue


APPLY
For Medical Assistance
Tax information-Household Members
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 33.0%
We may use Federal tax info to see if you can get Medicaid. Please tell us more by filling in the information below. For additional information, please click here.
CURRENT YEAR TAX RETURN
Willoughby Testingperson
Based on this person's current situation, does this person plan to file a Federal income tax return?*
No
Will this person be claimed as a dependent on someone else's tax return?*
Yes
No
Who will claim this person on their tax return?*
Jebediah Testingperson
OTHER DEPENDENTS
Back
Save and Continue

APPLY

For Medical Assistance

Information about the people living in your home

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 33.0%

Primary Applicant	Jebediah Testingperson
Household Members	Opal Testingperson
	Willoughby Testingperson

Show All | Hide All

Opal Testingperson

Information about the people living in your home — Hide Details

First Name:*	Opal
Middle Name/Initial:	
Last Name:*	Testingperson
Suffix:	
Maiden Name:	
Date of Birth(mm/dd/yyyy):*	02/02/1972
Does this person live at the same address as you?	Yes

Edit

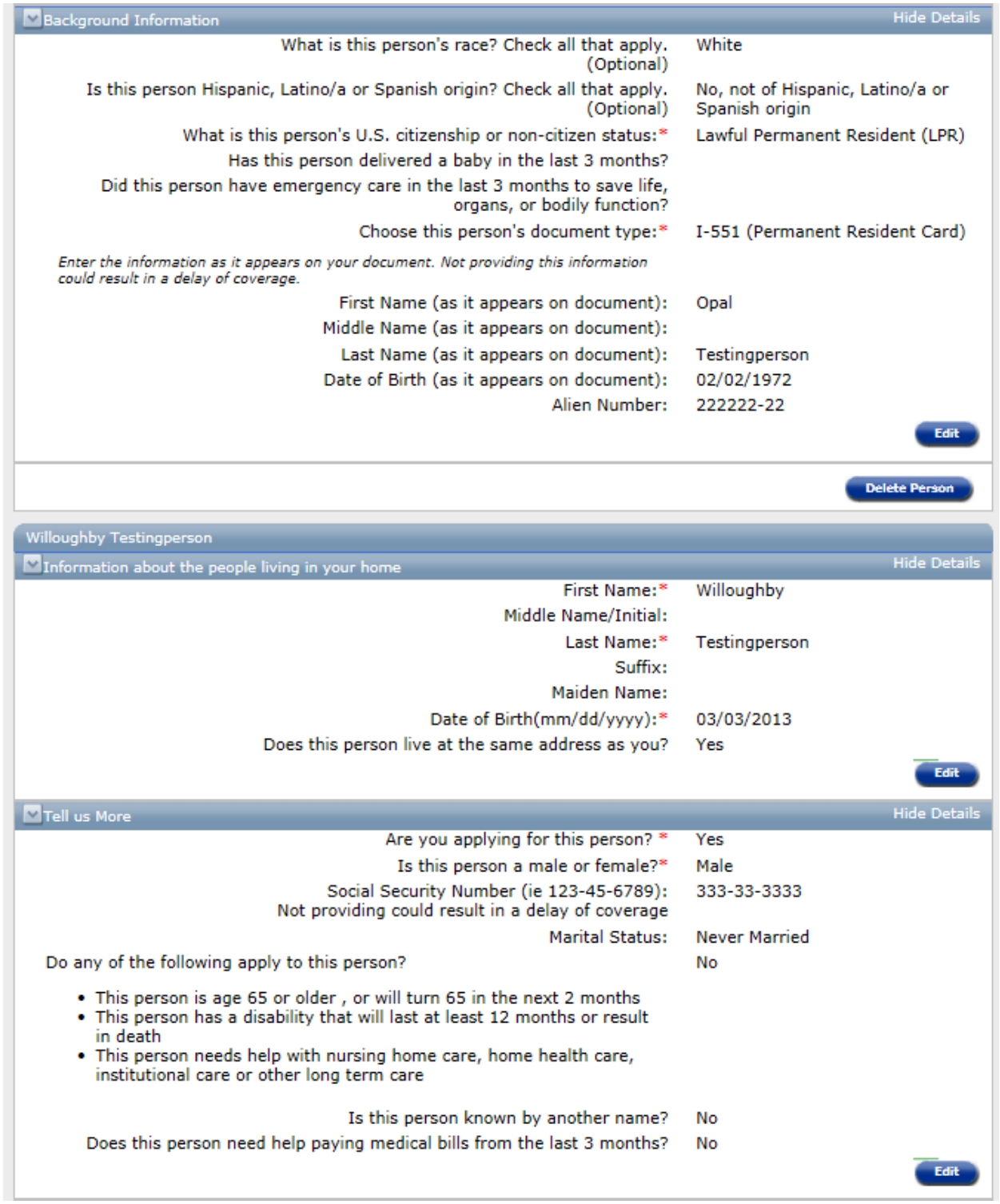
Tell us More — Hide Details

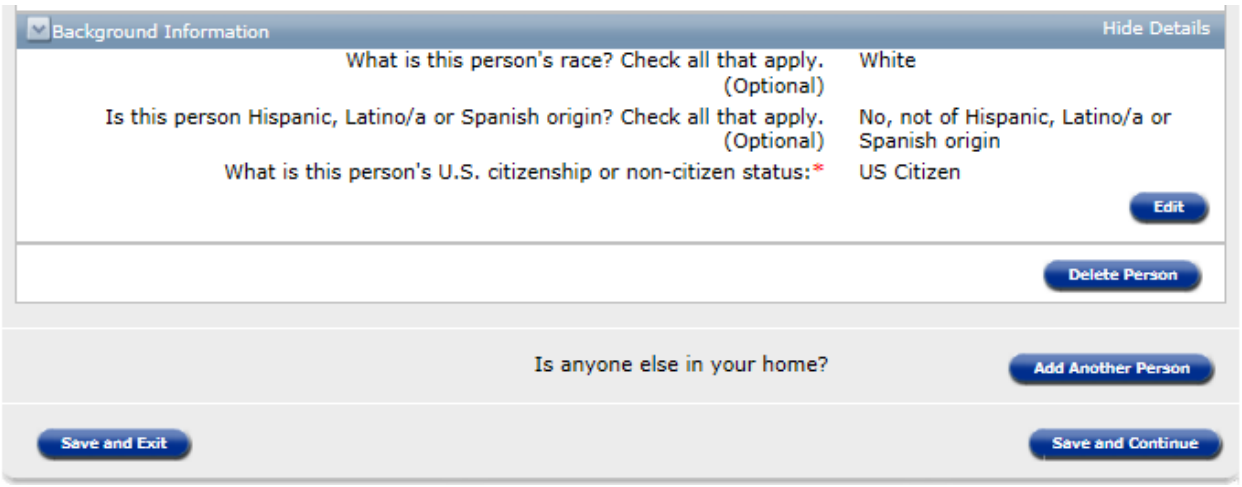
Are you applying for this person? *	Yes
Is this person a male or female?*	Female
Social Security Number (ie 123-45-6789): Not providing could result in a delay of coverage	
Marital Status:	Married
Do any of the following apply to this person?	No

- This person is age 65 or older , or will turn 65 in the next 2 months
- This person has a disability that will last at least 12 months or result in death
- This person needs help with nursing home care, home health care, institutional care or other long term care

Is this person known by another name?	No
Does this person need help paying medical bills from the last 3 months?	No
Is this person Pregnant?	No

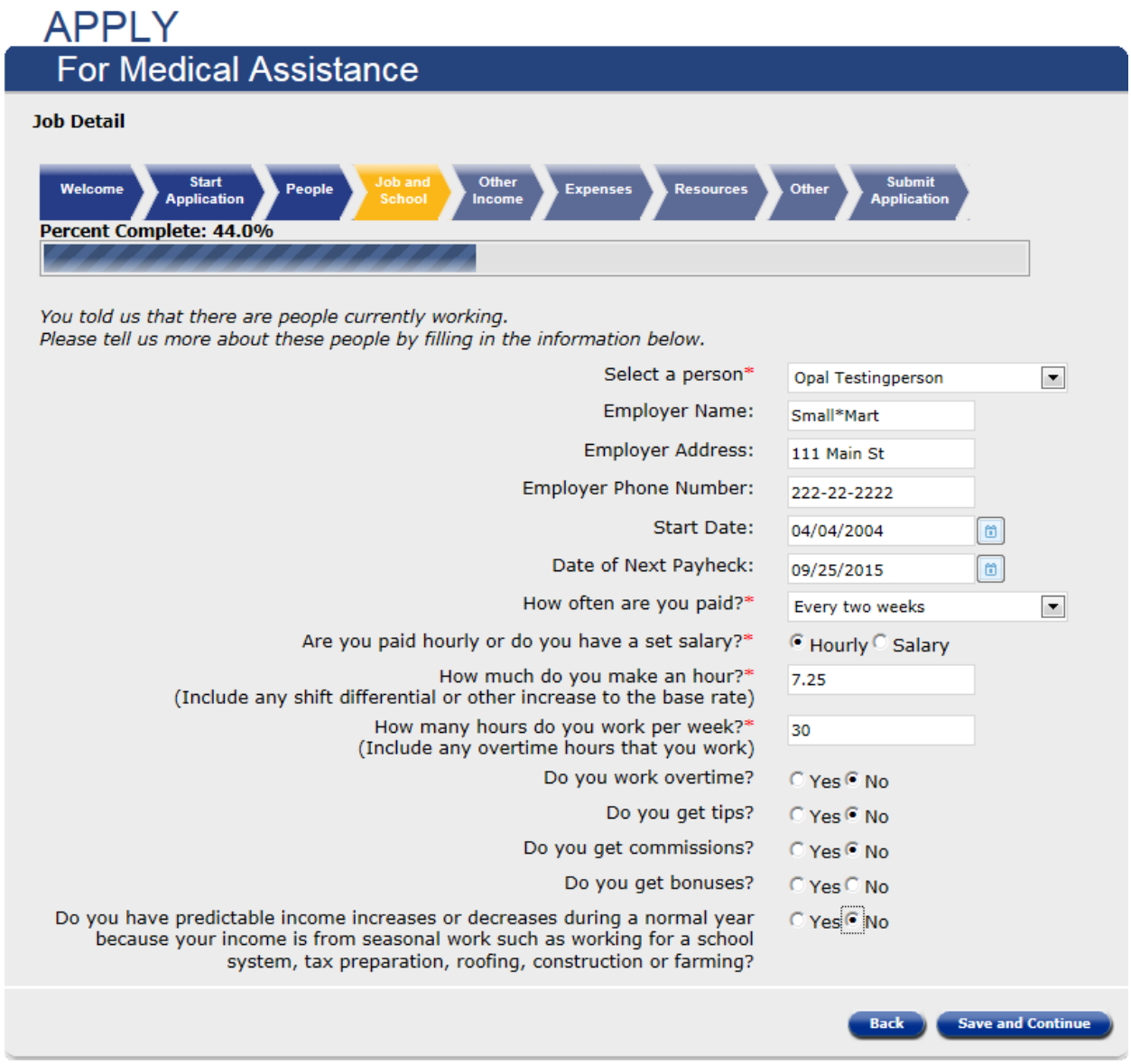
Edit

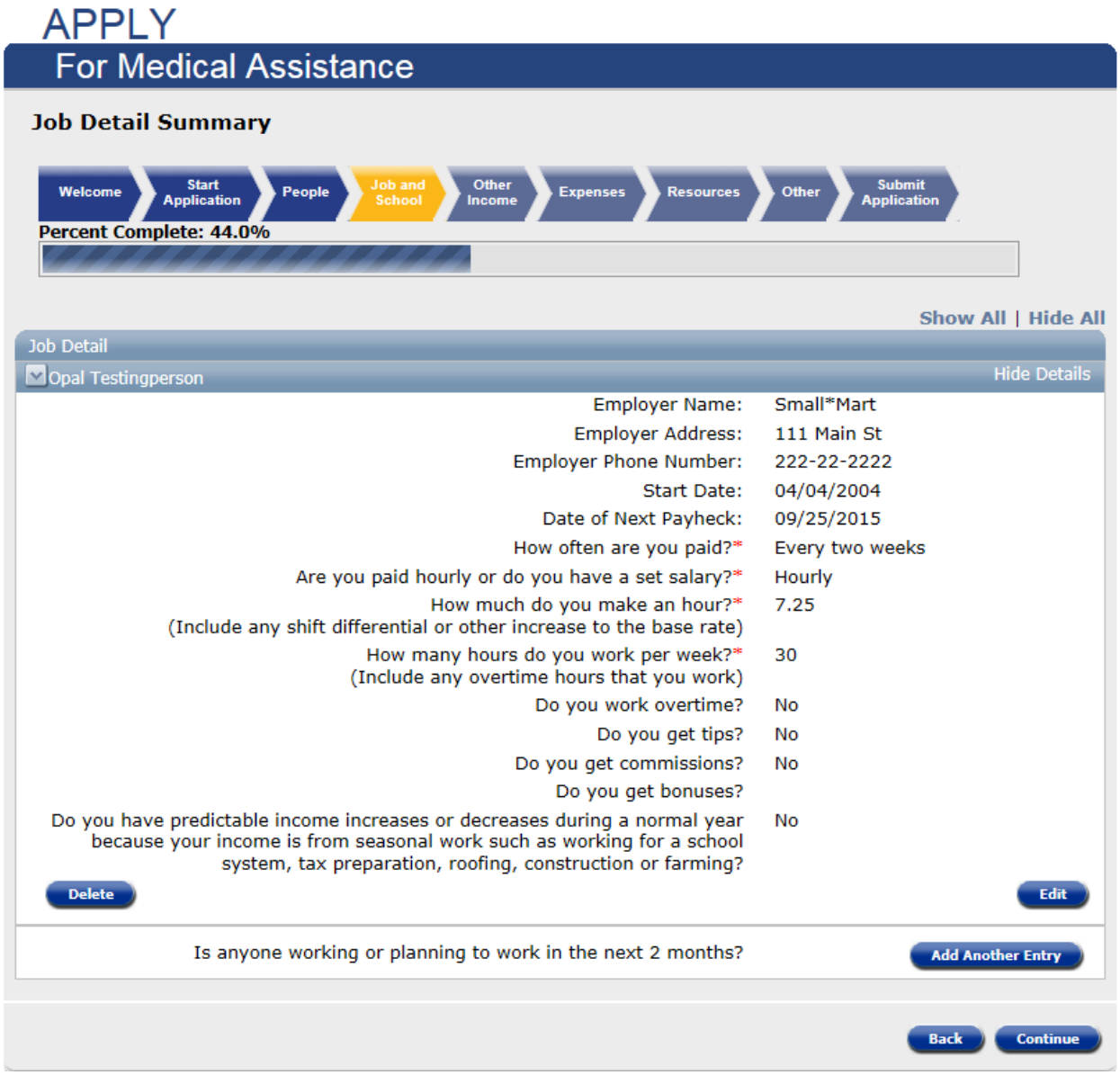

Background Information
Hide Details
What is this person's race? Check all that apply. (Optional)
White
Is this person Hispanic, Latino/a or Spanish origin? Check all that apply. (Optional)
No, not of Hispanic, Latino/a or Spanish origin
What is this person's U.S. citizenship or non-citizen status:*
Lawful Permanent Resident (LPR)
Has this person delivered a baby in the last 3 months?
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?
Choose this person's document type:*
I-551 (Permanent Resident Card)
Enter the information as it appears on your document. Not providing this information could result in a delay of coverage.
First Name (as it appears on document):
Opal
Middle Name (as it appears on document):
Last Name (as it appears on document):
Testingperson
Date of Birth (as it appears on document):
02/02/1972
Alien Number:
222222-22
Edit
Delete Person
Willoughby Testingperson
Information about the people living in your home
Hide Details
First Name:*
Willoughby
Middle Name/Initial:
Last Name:*
Testingperson
Suffix:
Maiden Name:
Date of Birth(mm/dd/yyyy):*
03/03/2013
Does this person live at the same address as you?
Yes
Edit
Tell us More
Hide Details
Are you applying for this person? *
Yes
Is this person a male or female?*
Male
Social Security Number (ie 123-45-6789):
Not providing could result in a delay of coverage
333-33-3333
Marital Status:
Never Married
Do any of the following apply to this person?
No
This person is age 65 or older , or will turn 65 in the next 2 months
This person has a disability that will last at least 12 months or result in death
This person needs help with nursing home care, home health care, institutional care or other long term care
Is this person known by another name?
No
Does this person need help paying medical bills from the last 3 months?
No
Edit

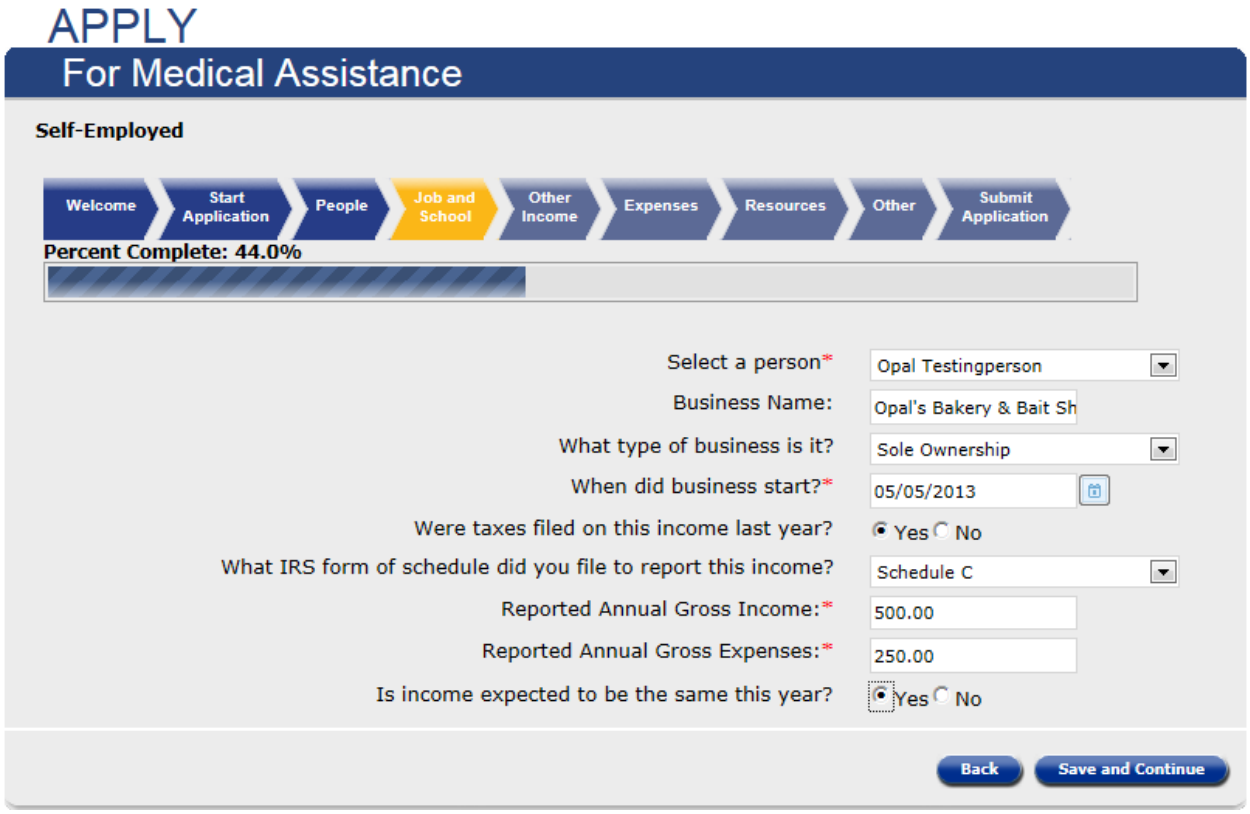

Background Information
Hide Details
What is this person's race? Check all that apply. (Optional)
White
Is this person Hispanic, Latino/a or Spanish origin? Check all that apply. (Optional)
No, not of Hispanic, Latino/a or Spanish origin
What is this person's U.S. citizenship or non-citizen status:*
US Citizen
Edit
Delete Person
Is anyone else in your home?
Add Another Person
Save and Exit
Save and Continue

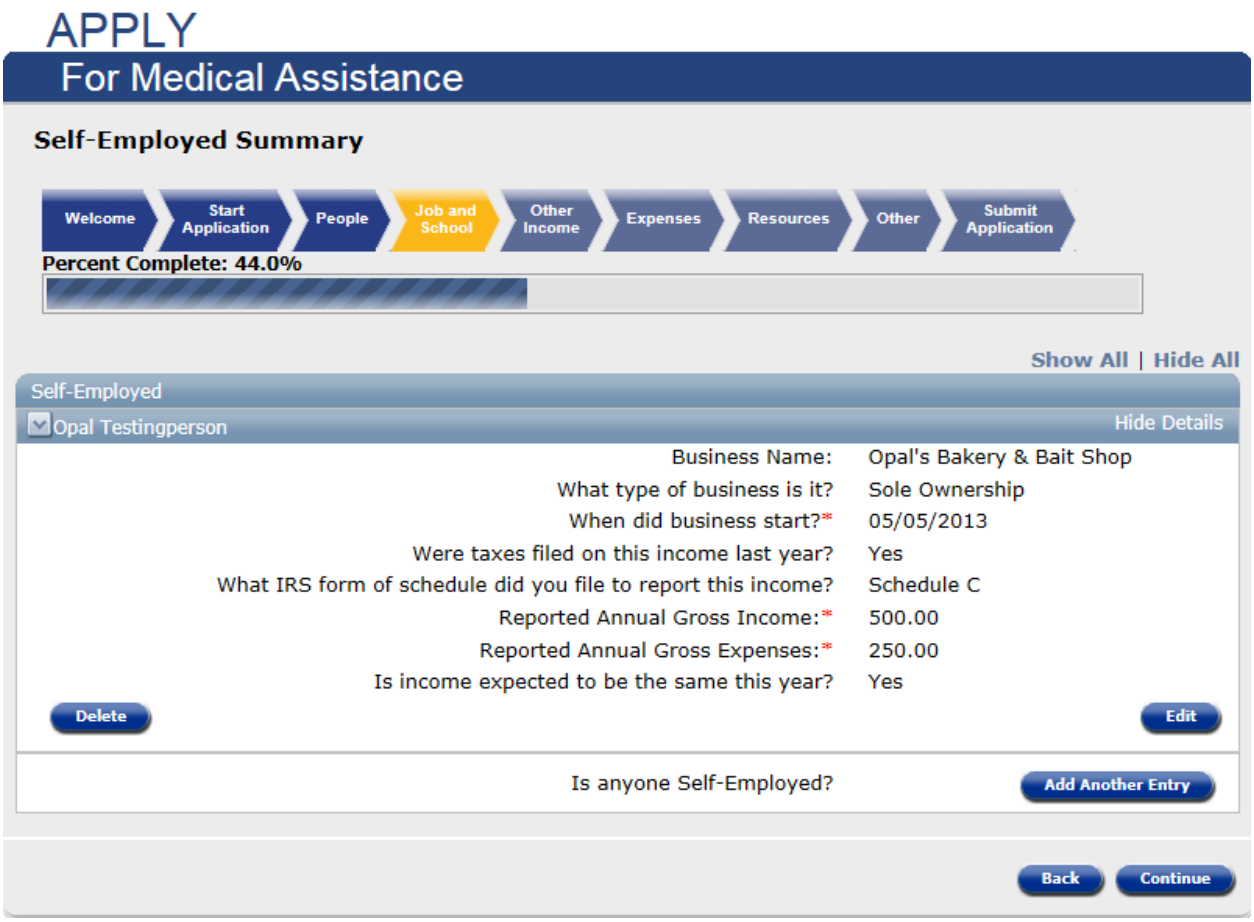
Job/Wages

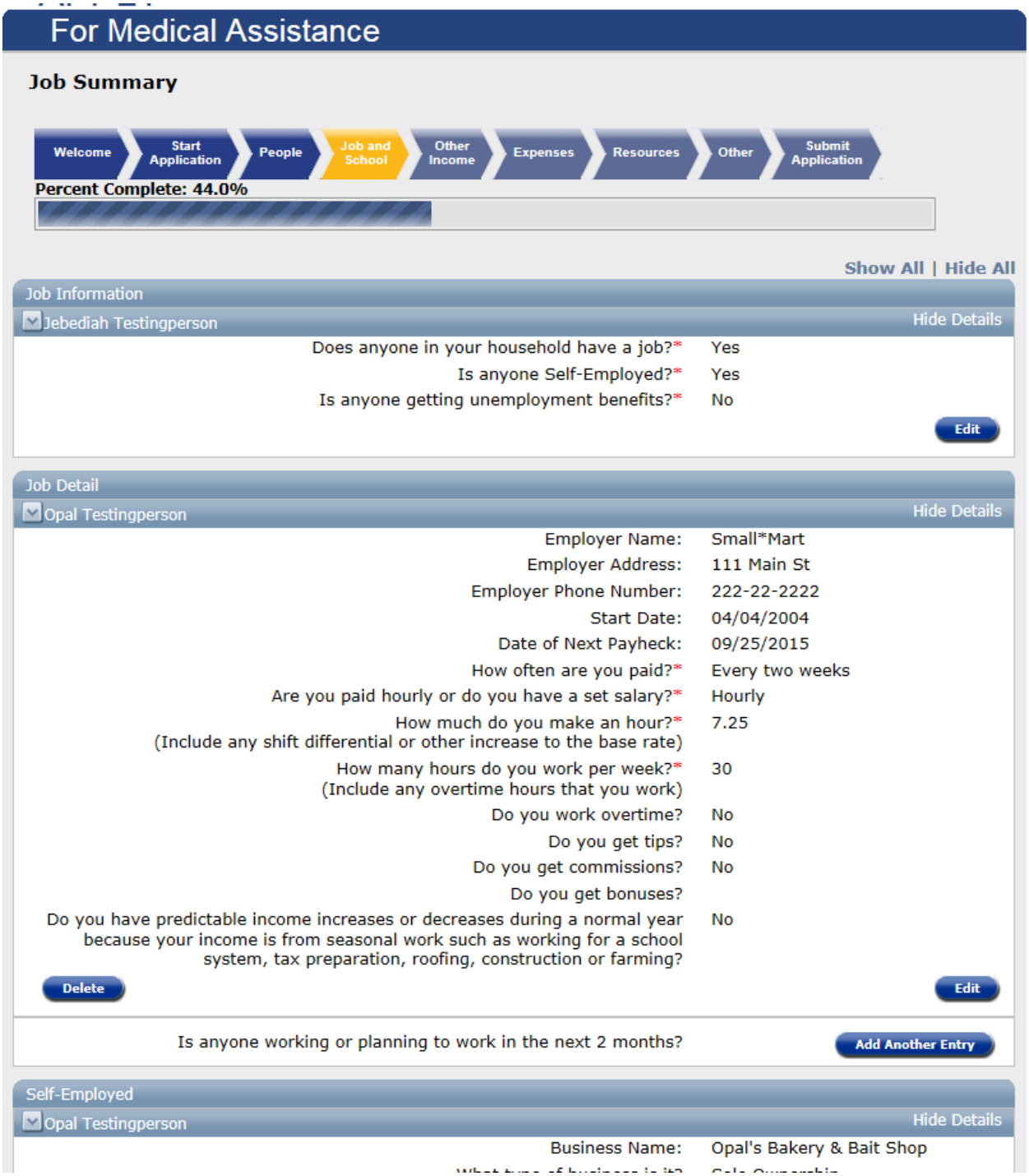

APPLY
For Medical Assistance
Job Information
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 44.0%
Jebediah Testingperson
Does anyone in your household have a job?*
Yes No
Is anyone Self-Employed?*
Yes No
Is anyone getting unemployment benefits?*
Yes No
Back
Save and Continue


APPLY
For Medical Assistance
Job Detail
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 44.0%
You told us that there are people currently working.
Please tell us more about these people by filling in the information below.
Select a person*
Opal Testingperson
Employer Name:
Small*Mart
Employer Address:
111 Main St
Employer Phone Number:
222-22-2222
Start Date:
04/04/2004
Date of Next Payheck:
09/25/2015
How often are you paid?*
Every two weeks
Are you paid hourly or do you have a set salary?*
Hourly
Salary
How much do you make an hour?*
(Include any shift differential or other increase to the base rate)
7.25
How many hours do you work per week?*
(Include any overtime hours that you work)
30
Do you work overtime?
Yes
No
Do you get tips?
Yes
No
Do you get commissions?
Yes
No
Do you get bonuses?
Yes
No
Do you have predictable income increases or decreases during a normal year because your income is from seasonal work such as working for a school system, tax preparation, roofing, construction or farming?
Yes
No
Back
Save and Continue

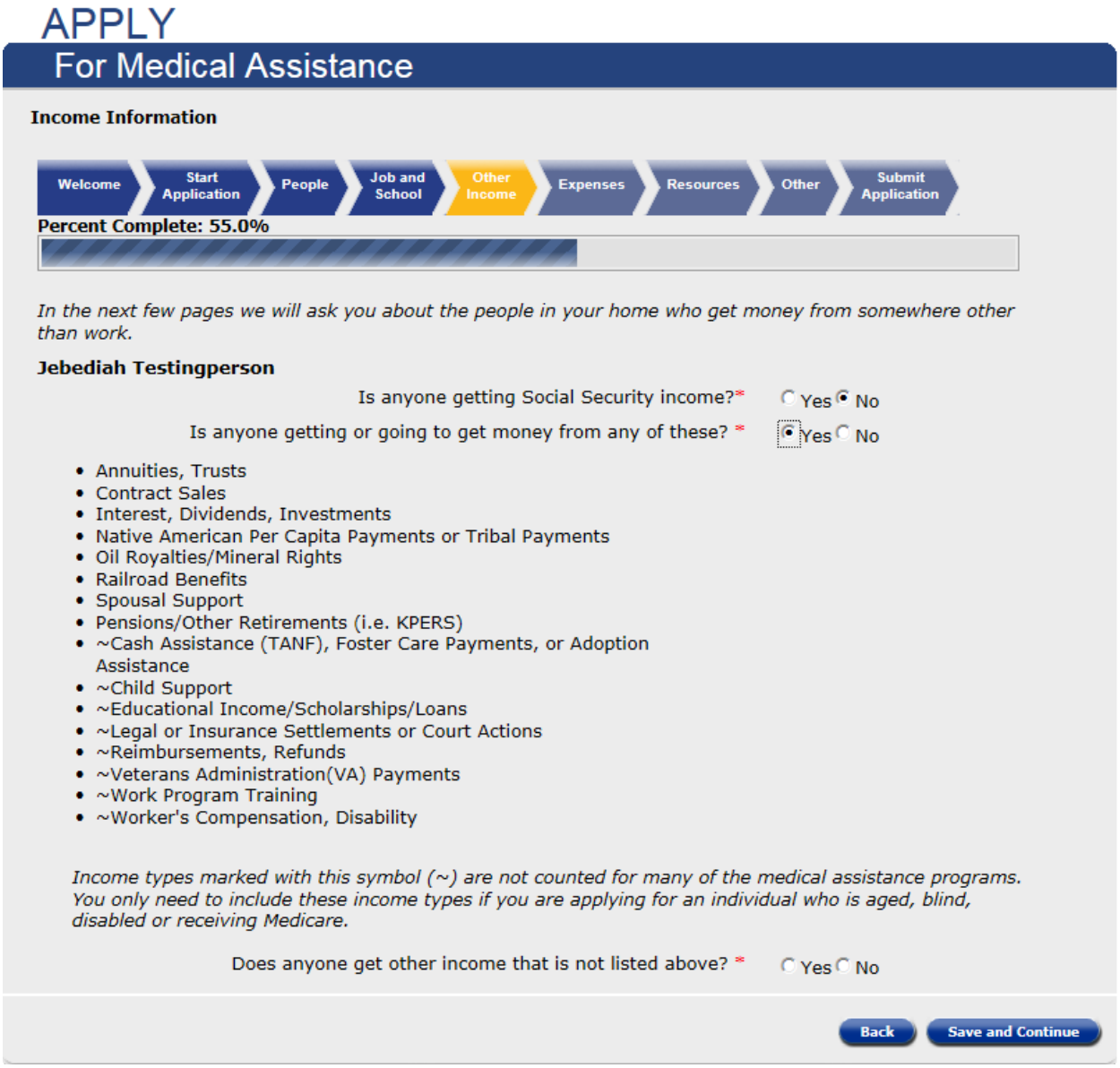

APPLY
For Medical Assistance
Job Detail Summary
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 44.0%
Show All | Hide All
Job Detail
Opal Testingperson
Hide Details
Employer Name: Small*Mart
Employer Address: 111 Main St
Employer Phone Number: 222-22-2222
Start Date: 04/04/2004
Date of Next Payheck: 09/25/2015
How often are you paid?* Every two weeks
Are you paid hourly or do you have a set salary?* Hourly
How much do you make an hour?* 7.25
(Include any shift differential or other increase to the base rate)
How many hours do you work per week?* 30
(Include any overtime hours that you work)
Do you work overtime? No
Do you get tips? No
Do you get commissions? No
Do you get bonuses?
Do you have predictable income increases or decreases during a normal year because your income is from seasonal work such as working for a school system, tax preparation, roofing, construction or farming? No
Delete
Edit
Is anyone working or planning to work in the next 2 months?
Add Another Entry
Back
Continue


APPLY
For Medical Assistance
Self-Employed
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 44.0%
Select a person*
Opal Testingperson
Business Name:
Opal's Bakery & Bait Sh
What type of business is it?
Sole Ownership
When did business start?*
05/05/2013
Were taxes filed on this income last year?
Yes
No
What IRS form of schedule did you file to report this income?
Schedule C
Reported Annual Gross Income:*
500.00
Reported Annual Gross Expenses:*
250.00
Is income expected to be the same this year?
Yes
No
Back
Save and Continue


APPLY
For Medical Assistance
Self-Employed Summary
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 44.0%
Show All | Hide All
Self-Employed
Opal Testingperson
Hide Details
Business Name: Opal's Bakery & Bait Shop
What type of business is it? Sole Ownership
When did business start?* 05/05/2013
Were taxes filed on this income last year? Yes
What IRS form of schedule did you file to report this income? Schedule C
Reported Annual Gross Income:* 500.00
Reported Annual Gross Expenses:* 250.00
Is income expected to be the same this year? Yes
Delete
Edit
Is anyone Self-Employed?
Add Another Entry
Back
Continue


For Medical Assistance
Job Summary
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 44.0%
Show All | Hide All
Job Information
Jebediah Testingperson
Hide Details
Does anyone in your household have a job?* Yes
Is anyone Self-Employed?* Yes
Is anyone getting unemployment benefits?* No
Edit
Job Detail
Opal Testingperson
Hide Details
Employer Name: Small*Mart
Employer Address: 111 Main St
Employer Phone Number: 222-22-2222
Start Date: 04/04/2004
Date of Next Payheck: 09/25/2015
How often are you paid?* Every two weeks
Are you paid hourly or do you have a set salary?* Hourly
How much do you make an hour?* (Include any shift differential or other increase to the base rate) 7.25
How many hours do you work per week?* (Include any overtime hours that you work) 30
Do you work overtime? No
Do you get tips? No
Do you get commissions? No
Do you get bonuses?
Do you have predictable income increases or decreases during a normal year because your income is from seasonal work such as working for a school system, tax preparation, roofing, construction or farming? No
Delete
Edit
Is anyone working or planning to work in the next 2 months?
Add Another Entry
Self-Employed
Opal Testingperson
Hide Details
Business Name: Opal's Bakery & Bait Shop

Other Income



APPLY

For Medical Assistance

Income from Other Sources

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 55.0%

You told us that there are people in your home who get or might get money from some of the sources below. Please tell us more about these people by filling in the information below.

Select a person*	Jebediah Testingperson
Income Category: *	Contract sales
How often? *	Once a month
How much? *	50.00

These income types are not counted for many of the medical assistance programs. You only need to include if you are applying for an individual who is aged, blind, disabled, or receiving Medicare.

- Cash Assistance (TANF), Foster Care Payments, or Adoption Assistance
- Worker's Compensation, Disability
- Educational Income/Scholarships/Loans
- Legal or Insurance Settlements or Court Actions
- Reimbursements, Refunds
- Work Program Training
- Child Support
- Veterans Administration(VA) Payments

What is the address of the property?

Back | Save and Continue

APPLY

For Medical Assistance

Income from Other Sources Summary

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 55.0%

Show All | Hide All

Income from Other Sources

Jebediah Testingperson — Hide Details

Income Category: *	Contract sales
How often? *	Once a month
How much? *	50.00

These income types are not counted for many of the medical assistance programs. You only need to include if you are applying for an individual who is aged, blind, disabled, or receiving Medicare.

- Cash Assistance (TANF), Foster Care Payments, or Adoption Assistance
- Worker's Compensation, Disability
- Educational Income/Scholarships/Loans
- Legal or Insurance Settlements or Court Actions
- Reimbursements, Refunds
- Work Program Training
- Child Support
- Veterans Administration(VA) Payments

What is the address of the property?

Delete | Edit

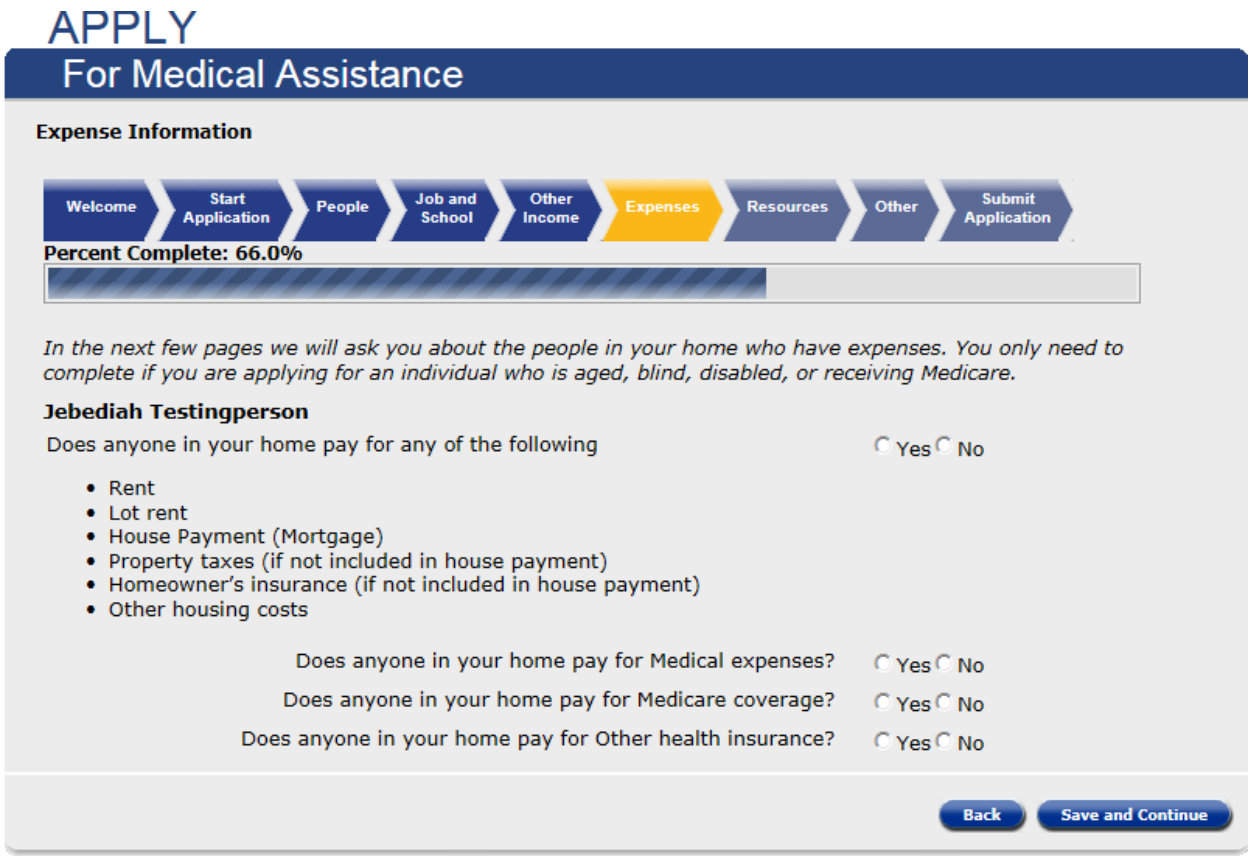
Is anyone getting or going to get money from any of these? This includes children.

Add Another Entry

- Cash assistance (TANF, Refugee Assistance, CAPI, General Assistance/Relief, Tribal TANF)?
- Veterans Administration payments such as Disability, Education, Aid and Attendance
- Social Security Benefits or SSI/SSP, Railroad Retirement Board (Disability or Retirement)
- Other pension or disability
- Retirement
- Loan, gifts, contribution
- Workers Compensation
  Military Allotment

Back | Continue

Expenses


APPLY
For Medical Assistance
Expense Information
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 66.0%
In the next few pages we will ask you about the people in your home who have expenses. You only need to complete if you are applying for an individual who is aged, blind, disabled, or receiving Medicare.
Jebediah Testingperson
Does anyone in your home pay for any of the following
Yes No
Rent
Lot rent
House Payment (Mortgage)
Property taxes (if not included in house payment)
Homeowner's insurance (if not included in house payment)
Other housing costs
Does anyone in your home pay for Medical expenses?
Yes No
Does anyone in your home pay for Medicare coverage?
Yes No
Does anyone in your home pay for Other health insurance?
Yes No
Back
Save and Continue

Resources

APPLY

For Medical Assistance

Resources Information

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 77.0%

In the next few pages we will ask you about the people in your home who have resources. You only need to complete if you are applying for an individual who is aged, blind, disabled, or receiving Medicare.

Jebediah Testingperson

Has anyone 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? ○ Yes ○ No

Does anyone own a home? Is anyone buying a home or other property such as land, buildings, or mobile homes? ○ Yes ○ No

Does anyone own one or more of the motor vehicles listed below? ○ Yes ○ No

- Car
- Truck
- RV
- Boat, Off-road vehicle, Mobile home, Camper, Trailer

Does anyone have any cash, stocks, bonds or bank accounts? ○ Yes ○ No

- Cash
- Checking, Savings or Credit Union account
- Certificate of Deposit (CD)
- Money Market
- Stocks/Bonds
- Other Accounts

Does anyone have any retirement plans? ○ Yes ○ No

- IRA, Keough, or 401(K)
- Deferred Compensation Plan
- Annuity
- Other Retirement plan

Does anyone have any of these types of resources? ○ Yes ○ No

- Life Insurance
- Life Estate
- Burial/Funeral Plan
- Oil/Mineral Rights
- Trust Fund
- Promissory Note/Contract Sales/Loans
- Reverse mortgage
- Business Property
- Other resources

Back | Save and Continue

Other

APPLY

For Medical Assistance

Other Information

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

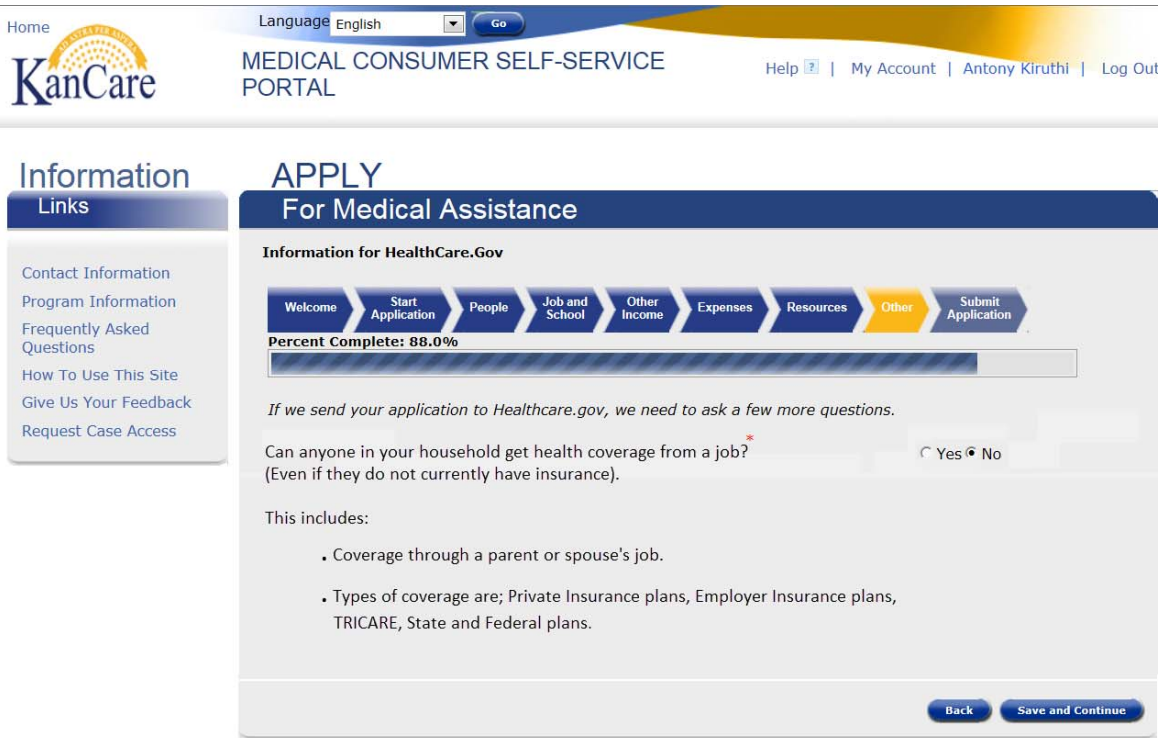
Percent Complete: 88.0%

In the next few pages we will ask you additional questions about the people in your home.

Jebediah Testingperson

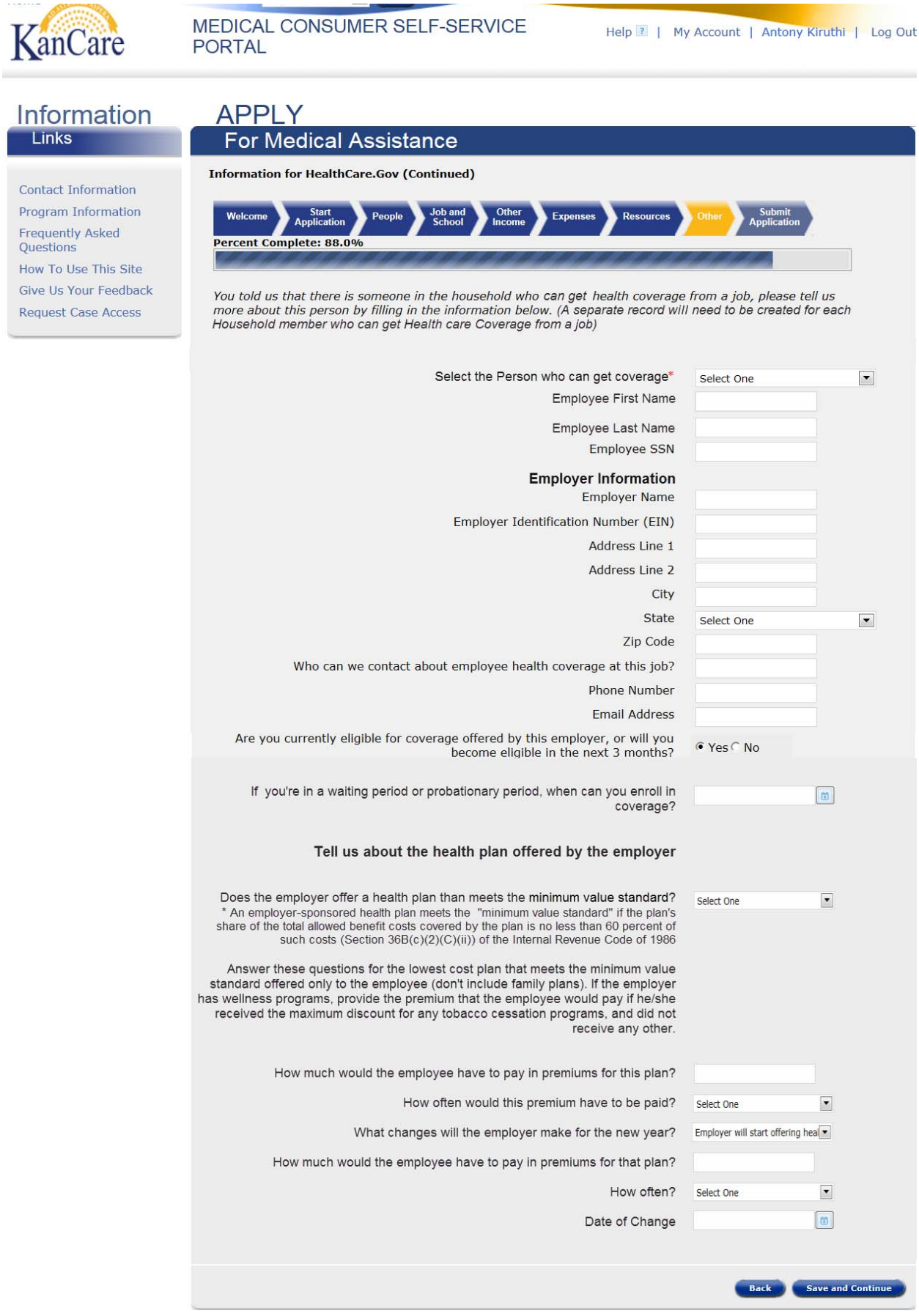
Does everyone live in Kansas?	(•) Yes ( ) No
Does anyone get public assistance from the State of Kansas?	( ) Yes (•) No
Have you, or any member of your household, served in the military or been married to a person who served in the military?	( ) Yes (•) No
Is there anyone in the home that currently has other health insurance?	( ) Yes (•) No
Is there anyone in the home that has health insurance that ended in the past 3 months?	( ) Yes (•) No
Is there anyone in your home who has been in a hospital or nursing facility for more than 30 days in a row?	( ) Yes (•) No

Back | Save and Continue



Note: This page is used to display the initial Employee-Sponsored Insurance question. If this application fails the federal poverty level (FPL) assessment and "Can anyone in your household get health coverage from a job" is answered "Yes," the *Information for HealthCare.Gov (Continued)* screen will be displayed.

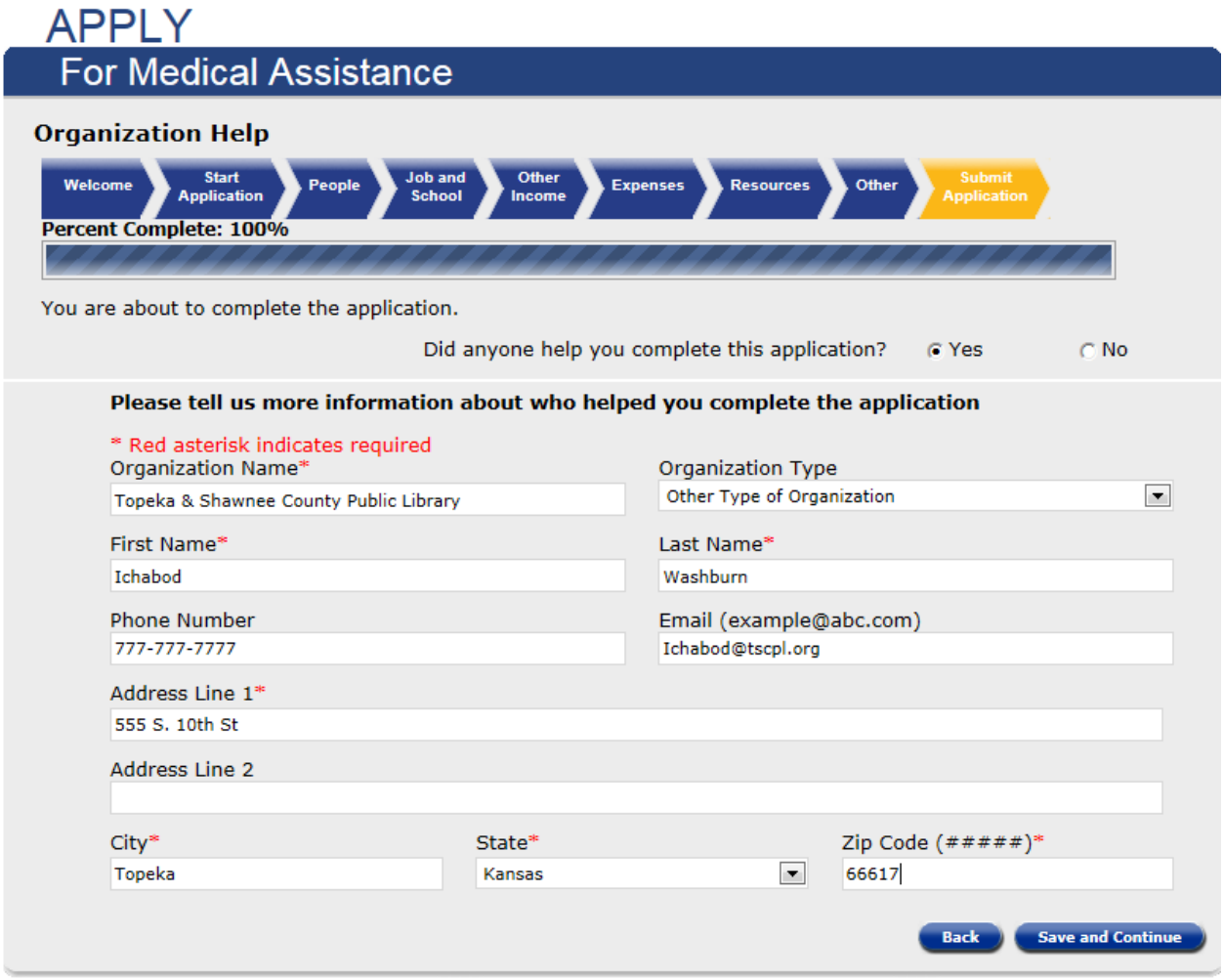
The current screen displays a chart with the monthly income limits and asks the consumer if their household income is greater than the limit. The change for October 2015 calculates an estimated income and removes the chart.

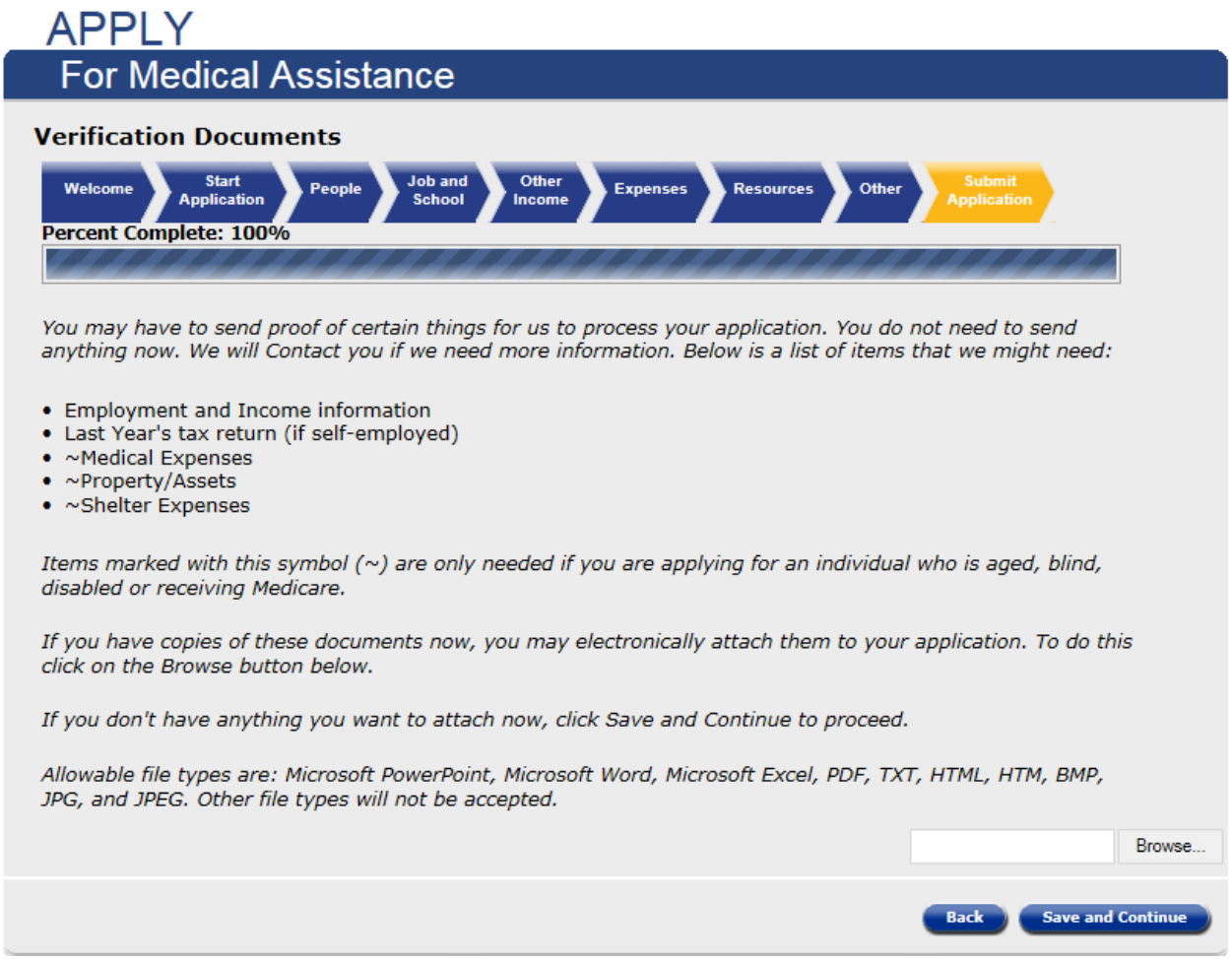

KanCare
MEDICAL CONSUMER SELF-SERVICE PORTAL
Help | My Account | Antony Kiruthi | Log Out
Information
Links
Contact Information
Program Information
Frequently Asked Questions
How To Use This Site
Give Us Your Feedback
Request Case Access
APPLY
For Medical Assistance
Information for HealthCare.Gov (Continued)
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 88.0%
You told us that there is someone in the household who can get health coverage from a job, please tell us more about this person by filling in the information below. (A separate record will need to be created for each Household member who can get Health care Coverage from a job)
Select the Person who can get coverage*
Select One
Employee First Name
Employee Last Name
Employee SSN
Employer Information
Employer Name
Employer Identification Number (EIN)
Address Line 1
Address Line 2
City
State
Select One
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?
Yes
No
If you're in a waiting period or probationary period, when can you enroll in coverage?
Tell us about the health plan offered by the employer
Does the employer offer a health plan than meets the minimum value standard?
* 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
Answer these questions 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.
How much would the employee have to pay in premiums for this plan?
How often would this premium have to be paid?
What changes will the employer make for the new year?
Employer will start offering hea
How much would the employee have to pay in premiums for that plan?
How often?
Date of Change
Back
Save and Continue

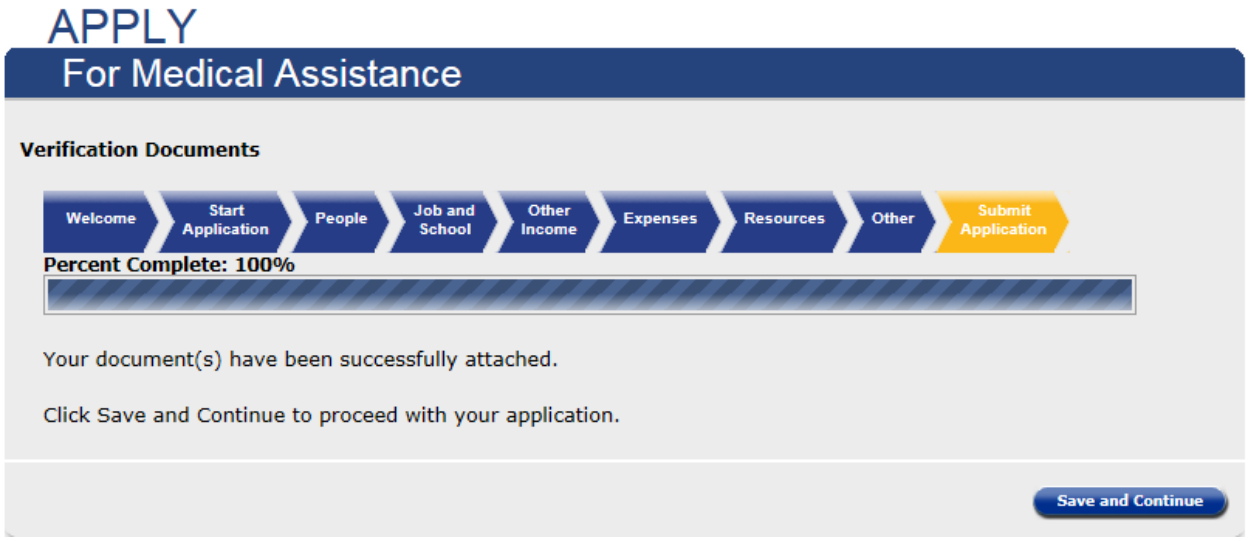
Note: The HealthCare.gov summary screen allows for multiple entries.


APPLY
For Medical Assistance
American Indian or Alaska Native Information
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 88.0%
Complete this page if you or family members are American Indian or Alaska Native.
Jebediah Testingperson
Are you or any of your family members American Indian or Alaska Native?
Yes
No
Back
Save and Continue

Submit Application




APPLY
For Medical Assistance
Verification Documents
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 100%
You may have to send proof of certain things for us to process your application. You do not need to send anything now. We will Contact you if we need more information. Below is a list of items that we might need:
• Employment and Income information
• Last Year's tax return (if self-employed)
• ~Medical Expenses
• ~Property/Assets
• ~Shelter Expenses
Items marked with this symbol (~) are only needed if you are applying for an individual who is aged, blind, disabled or receiving Medicare.
If you have copies of these documents now, you may electronically attach them to your application. To do this click on the Browse button below.
If you don't have anything you want to attach now, click Save and Continue to proceed.
Allowable file types are: Microsoft PowerPoint, Microsoft Word, Microsoft Excel, PDF, TXT, HTML, HTM, BMP, JPG, and JPEG. Other file types will not be accepted.
Browse...
Back
Save and Continue


APPLY
For Medical Assistance
Verification Documents
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 100%
Your document(s) have been successfully attached.
Click Save and Continue to proceed with your application.
Save and Continue


APPLY
For Medical Assistance
Health Plan Choice
Welcome
Start Application
People
Job and School
Other Income
Expenses
Resources
Other
Submit Application
Percent Complete: 100%
Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please review the health plan information and choose a plan. If you choose, we will enroll you in that plan if eligible for KanCare. If you do not choose, a plan will be assigned for you. If you do not like your assignment, you will have 90 days to change plans. You will receive a packet of information about your plan.
Note: For persons who are not eligible for a KanCare plan, information about coverage and services will be sent separately.
Click here to learn about the KanCare Health Plans *
Amerigroup RealSolutions in healthcare
SUNFLOWER STATE HEALTH PLAN
UnitedHealthcare Community Plan
Choose AmeriGroup
Choose Sunflower
Choose UnitedHealthcare
Back
Save and Continue

APPLY

For Medical Assistance

E-Signature

Welcome | Start Application | People | Job and School | Other Income | Expenses | Resources | Other | Submit Application

Percent Complete: 100%

Read all of the information below very carefully. When you are done, check the checkbox on the bottom to indicate you agree that all the information you provided in the application is accurate. You can still change information on your application now; however, once you click the 'Submit Application' button below this will submit your application and you will not be able to make any further changes.

You must electronically sign this application before it can be submitted.

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 premium if I qualify for either Working Healthy or KanCare - CHIP. The premium may be as little as $0 or as much as $152 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 on any medical and other health services furnished to those for whom I am applying while 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, and KDADS or other benefit programs, any information including financial and other confidential information necessary to establish my eligibility.

Would you like us to send you a voter registration card? (•) Yes ( ) No

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.

Check to Sign* [☑] Name* Jebediah Testingperson

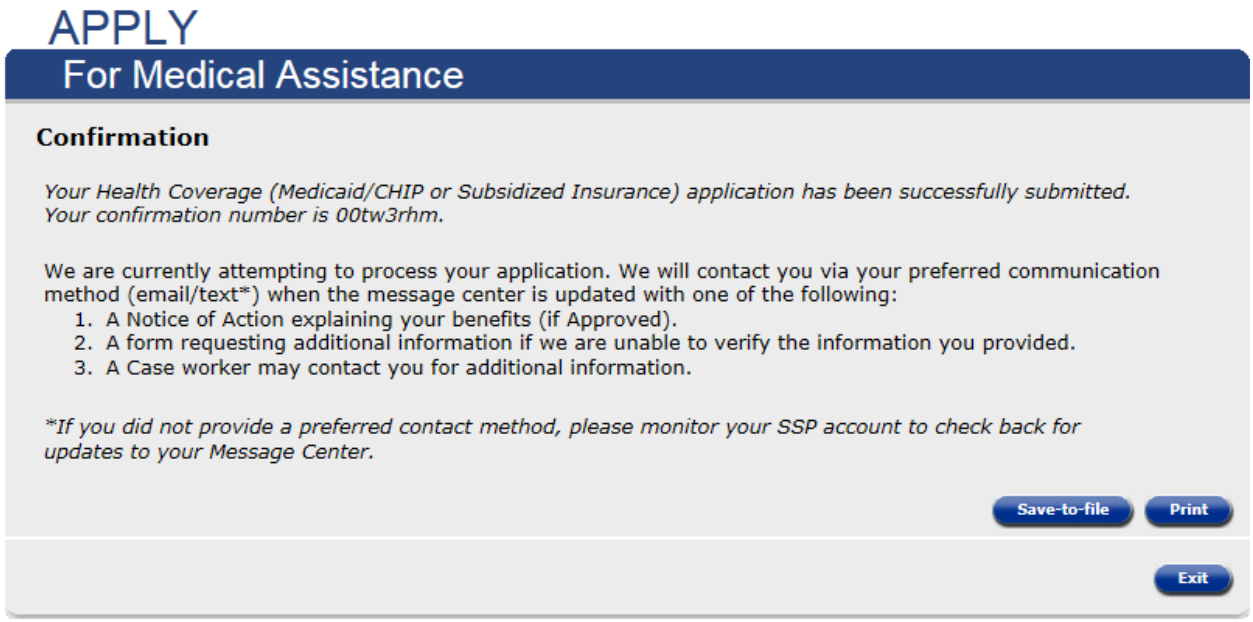
Choose one of the options below: *

(•) I am signing this application on behalf of myself and/or my dependents.

( ) I am a legal representative (power of attorney, legal guardian) of the person seeking coverage.

( ) I am applying on behalf of someone for whom I have no legal relationship.

Back Submit Application


APPLY
For Medical Assistance
Confirmation
Your Health Coverage (Medicaid/CHIP or Subsidized Insurance) application has been successfully submitted.
Your confirmation number is 00tw3rhm.
We are currently attempting to process your application. We will contact you via your preferred communication method (email/text*) when the message center is updated with one of the following:
1. A Notice of Action explaining your benefits (if Approved).
2. A form requesting additional information if we are unable to verify the information you provided.
3. A Case worker may contact you for additional information.
*If you did not provide a preferred contact method, please monitor your SSP account to check back for updates to your Message Center.
Save-to-file
Print
Exit