Kansas Department of Health and Environment
Division of Health Care Finance

ES-3100.7
01-13

APPLICATION FOR MEDICAL ASSISTANCE
Breast and Cervical Cancer

☐ New Application ☐ Recertification

Name: _____ Phone: _____

Address: _____ Message Phone #: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing Address (if different): _____ Social Security #: _____

City: _____ State: _____ Zip: _____ U.S. Citizen ☐ Yes ☐ No

1. Are you married: ☐ No ☐ Yes, name of spouse _____
2. Are you pregnant? ☐ No ☐ Yes, due date _____
3. Do you have dependent children? ☐ No ☐ Yes, list names and ages: _____
4. Do you get or have you applied for Social Security disability benefits? ☐ No ☐ Yes, list application or approval date _____
5. Do you want medical assistance for the past three months? ☐ No ☐ Yes
6. If approved for medical assistance, your services will be provided by KanCare. There are 3 KanCare health plans to choose from. Please review the *Health Plan Highlights* and choose your plan. If you do not choose, a plan will be assigned for you. You will have 90 days to change plans. You will receive a packet of information about your plan. Check the box next to your choice.

☐ Amerigroup ☐ Sunflower State Health Plan ☐ UnitedHealthcare

NOTE: For initial applications this form must be accompanied by the Intake and Visit Summary used by the Early Detection Works.

STATEMENT OF UNDERSTANDING AND AGREEMENT

- I understand this is an application for one type of Medicaid assistance only. A different form may need to be completed to determine eligibility under other groups.
- I understand that disclosure of confidential information is limited to program administration purposes only.
- I agree that, upon approval for medical assistance, all rights to past, present, or future support and any rights to payment for medical care on behalf of anyone approved are automatically assigned to DCF.
- I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility. This may include inquiries of employers, medical providers, financial institutions, and other professional organizations.
- I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which KDHE may obtain the necessary proof.
- I understand that my signature authorizes the use of my (our) Social Security Number(s) to administer programs I have applied for.
- I understand that I have the responsibility to use and report any third-party resources that may have a legal obligation to pay any or all of my medical expenses. I hereby authorize payments under medical assistance to be made directly to medical providers on any future unpaid bills for health services furnished me while eligible. I understand that payment for a particular service may be withheld until a determination of payment from another source is made.
- I understand that my application will be considered without regard to race, color, sex, age, handicaps, religion, national origin, or political belief.
- I understand that I may request a fair hearing if I disagree with an agency decision on my case and that I may be represented by any person I choose.
- I certify that I, or any persons for whom I am applying, am a U.S. citizen or a non-citizen in lawful immigration status.
- I understand that if I receive medical assistance after age 54 or while in an institutional or HCBS 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 understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

AUTHORIZATION TO RELEASE INFORMATION

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

X_____ _____

Signature of Applicant, Guardian/Conservator, or Durable Power of Attorney **Date**