Kansas
Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884

Medicaid Application/Review Signature Page

Read the information below. Sign, date and return this page.

I understand:

- I have the right to equal treatment regardless of race, color, national origin, age, disability, sex, religion, or political belief.
- Federal law does not allow discrimination based on race, color, national origin, age, disability, or sex. I can file a discrimination complaint at https://khap2.kdhe.state.ks.us/kfmam/ civilrightscomplaint.asp.
- I have the right to have information I provided kept private unless directly related to the administration of Kansas medical assistance programs.
- Some or all of the people I am applying for may get similar health coverage under the Medicaid program if they qualify.
- 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 be legally obligated to pay any or all of the medical expense of people I am applying for. 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 institution, there may be a claim against my estate to recover the medical expenses paid for me. I understand that my financial institution 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 give 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 disagree with an agency decision or I think they did not follow all federal and state rules.
    - The office must get my hearing request within **33** days of the date on the decision notice.
    - I can ask for the hearing by phone or mail:
      Phone: **1-800-792-4884** (TTY 1-800-792-4292), **or**
      Mail: The Office of Administrative Hearings 1020 S. Kansas Ave Topeka, KS 66612
- I can represent myself at the hearing or I can have someone represent me. The hearing decision usually comes within 90 days of the request date.
- If I have an urgent medical need, I can ask for an expedited (fast) hearing:
    - I must send a medical professional's proof of the need with my request.
    - If approved, an expedited hearing will be scheduled as soon as possible.
    - If denied, the hearing will be scheduled in the usual time.
- I have to provide or apply for a Social Security Number (SSN) for anyone who is applying for health benefits, and I authorize use of the SSNs to administer the program. The SSNs will also be used for computer matches with other organizations such as banks, the Social Security Administration, and Internal Revenue Service.
- I am responsible to give correct income, address, and household composition information, and to report changes during the application process and while I am eligible.

I agree:

- To turn over any medical support payments for all persons receiving medical assistance if adults in the household qualify for medical assistance.
- To help Child Support Services (CSS) establish and enforce needed support orders if adults in the household qualify for medical assistance.
- To pay the Children's Health Insurance Program (CHIP) premium each month if I qualify for that program. The premium can be as low as $0 or as much as $50, depending on my income.
- To pay the Working Healthy premium each month if I qualify for that program. The premium may be as little as $0 or as much as $205 depending on my income.

I certify:

- That everyone I am requesting health coverage for who qualifies for coverage is a U.S. citizen, U.S. national, or non-U.S. citizen in lawful immigration status. Proof of immigration status may be required.
- 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 doctors and other medical providers or managed care organizations for covered medical and other health services.
- Medical providers to release medical information to: Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), Department for Children and Families (DCF) » Kansas Department for Aging and Disability Services (KDADS), U.S. Department of Health and Human Services, Insurance companies, Other contracted medical providers
- KDHE, DCF, and KDADS to share medical information for administrative purposes with other agencies and contractors.
- Banks, credit unions, and all other financial institutions to release my **financial information** to KDHE, DCF, KDADS or other benefit programs to find if I qualify. I allow this until my application is denied, my eligibility ends, or I end the permission in writing. If I refuse to give or I end this permission, my application may be denied, or I may no longer qualify.
- The groups below to release my **private information** to KDHE, DCF, KDADS or other benefit programs to find if I qualify: Employers, Medical providers, Insurance providers, Benefit providers, other persons or agencies as needed

By signing this form, I state that:

- **I have read and understood the conditions above.**
- **I understand that state and federal privacy laws protect all information I put on the application for my case.**
- **This release on my application is valid from the date on the form below.**
- **A copy of this signature page is as valid as the original.**

_____

Primary Applicant must sign here Date

_____

Other Adult applying, such as parent or spouse, **may** sign here (optional) Date

_____

If Primary Applicant is unable to sign, or signed with an “X”, Date
have a **first** witness sign here

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If Primary Applicant is unable to sign, or signed with an “X”, Date
have a **second** witness sign here

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Medical representative sign here (if any) Date