KanCare Health Care Access Improvement Program
Uncompensated Care Pool Application

Please Note: *Applicants for the HCAIP Uncompensated Care Pool must complete the Kansas UCC/DSH Survey. Data from the Survey populates this application.*

General Information

Hospital Name:

Kansas Medicaid Provider Number(s)**:**

Medicare Provider Number:

Medicare Cost Report (2552-10) Fiscal Year: From: **«FYB»** To:

UC Demonstration Year: **2020 - DY 8**

Amount of Uncompensated Care (UC): $_____

Plus HCAIP Payments $_____

Less DSH Payment $ (_____)

Total UC for Pool Calculation: $ «Total UC for Pool»

Criteria for Additional Uniform Percentage

Did the hospital provide the following during the Medicare Cost Report Fiscal Year listed above?

Level II or Level III NICU services	Yes	No
Inpatient psychiatric service distinct part unit (beds)	Yes	No
Level I or Level II trauma services	Yes	No
Did the hospital system provide Level I, II and III NICU services?	Yes	No
Did the hospital have less than $300 million in Net Inpatient Revenue?	Yes	No

Signer must be an individual legally responsible for the conduct of the contracted hospital such as the Owner, a General Partner, a specifically authorized Corporation Officer or a Hospital Administrator.

_____ _____

Signature Date

_____ _____

Name (Print or type) Date

_____ _____

Email address Contact Phone Number