Table of Contents

State/Territory Name: Kansas

State Plan Amendment (SPA) #: KS-14-0012

This file contains the following documents in the order listed:

The complete title XXI state plan for Kansas consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/chip/state-program-information/chip-state-program-information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

Dr. Susan Mosier, M.D.
State Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
900 SW Jackson
Suite 900-N Landon State Office Building
Topeka, Kansas 66612-1220

DEC 2 2 2014

Dear Dr. Mosier:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Kansas' Children's Health Insurance Program (CHIP) state plan amendment (SPA), KS-14-0012-MC4 submitted on March 27, 2014. This SPA incorporates the Modified Adjusted Gross Income (MAGI)-based eligibility process requirements in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of KS-14-0012-MC4 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 state plan pages and attachments to be incorporated within a separate section at the end of Kansas' approved state plan:

- CS24
- Attachment 1 –Alternative single, streamlined paper application
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application

This approval and the enclosures supercede the following sections of the current CHIP state plan:

- Section 4.3: Single Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Mr. Martin Burian. He is available to answer questions concerning this amendment and other CHIP-related issues. Mr. Burian's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3246
Facsimile: (410) 786-5882
E-mail: Martin.Burian@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Burian and Mr. James Scott, Associate Regional Administrator, in our Kansas City Regional Office. Mr. Scott's address is:

Mr. James Scott
Office of the Regional Administrator
601 E. 12th Street, Suite 355
Kansas City, MO 64106

If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at 410-786-0719.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Eliot Fishman
Director

Enclosure

cc:
Mr. James Scott, ARA, CMS Kansas City Region

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

Dr. Susan Mosier, M.D.
State Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
900 SW Jackson
Suite 900-N Landon State Office Building
Topeka, Kansas 66612-1220

DEC 2 2 2014

Dear Dr. Mosier:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of Children's Health Insurance Program (CHIP) state plan amendment (SPA) transmittal KS-14-0012-MC4, which was submitted to CMS on March 27, 2014. Our review of this submission included a review of the alternative single streamlined online 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.

Necessary changes to online application	**Date by which changes will be completed:**
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

The 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 Ms. Victoria Collins at Victoria.Collins@cms.hhs.gov or (410) 786-2167. We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Kelly Whitener
Director
Division of State Coverage Programs

cc:
Mr. James Scott, ARA, CMS Kansas City Region

logged in as TONIABROWN(CMS CO Staff) read only mode application rev p01

Children's Health Insurance Program Eligibility

KS.0842.R00.00 - Oct 01, 2013

Home | Logout | Finder | Save | Validate | Print | Help

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

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-14-0012

Type of SPA:

- [ ] MAGI Eligibility & Methods
- [ ] XXI Medicaid Expansion
- [ ] Establish 2101(f) Group
- [x] Eligibility Processing
- [ ] Non-Financial Eligibility

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 457, subpart C

Federal Budget Impact

- [x] This SPA has a budget impact.

Total budget impact:

State Funds: $ 113000.00

Federal Funds: $ 262000.00

Please attach a revised CHIP budget.

Document

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count:57 out of 2000

KS MAGI CHIP Eligibility Processing State Plan Amendment.

Signature of State Agency Official

Submitted By: Bobbie Graff-Hendrixson

Last Revision Date:	Dec 23, 2014
Submit Date:	Mar 27, 2014

BACK CONTINUE

CHIP Eligibility

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

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing **CS24**

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

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 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 and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

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.

☑ 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 CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☒ Other electronic means:

	Name of method	Description	
+	Fax	Through facsimile machine	X

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

CHIP Eligibility

- ■ Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- ■ Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- ■ Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. [No]

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 457.343:
  - ■ 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.

Screening by Other Insurance Affordability Programs

- ☑ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
- ☐ The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

☑ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

V.20130917

KanCare

Application for Medical Assistance for Families with Children

Who can use this application?	This application is for families, children, and pregnant women. You can use this application to apply for anyone in your family, even if they have insurance now. If you are a childless adult, you may qualify for coverage through the Federal Health Insurance Marketplace at www.healthcare.gov
Use this application to see what choices you have	• Free or low-cost medical assistance from Medicaid or the Children's Health Insurance Program (CHIP) • If you are not approved for KanCare, your information may be sent to the Federal Health Insurance Marketplace. They will see if you can get other help paying for medical assistance.
Apply faster online	GO! Would you rather apply online? Apply faster online at www.applyforKanCare.ks.gov

Important! ➡ Is anyone who is requesting medical assistance pregnant?

☐ Yes ☐ No

Agency Use Only

Outstationed Worker ☐

For help completing this application, call toll free: **1-800-792-4884**

Approval Date: DEC 2 2 2014

A. Tell us about Yourself and the People in Your Home

Tell us about yourself. The person filling out this application is the Primary Applicant. This is usually the person who is "head of household."			
Your Name: (First, Middle, Last)		Other names used:	
Home Address:		Mailing Address (If different):	
City:	State:	City:	State:
County:	Zip:	County:	Zip:
☐ Check here if you don't have a home address. You still need to give a mailing address.			
Home Phone: ( ) —		Work Phone: ( ) —	
I would like to get information about this application by:			
Email: ☐ No ☐ Yes	Email Address:		
Text: ☐ No ☐ Yes	Cell Phone Number: ( ) —		
What language do you speak at home?		What language do you read at home?	

About Your Family

Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.

Here's who you need to include on this application:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your partner who lives with you (but only if you have children together who need medical assistance)
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

Anyone else who lives with you that is not listed above will need to file their own application if they want medical assistance. You don't need to file taxes to apply for medical assistance.

Complete the questions on the next few pages for each person in your family. Start with yourself!
If you have more than 6 people in your family, please attach another sheet of paper.

Your information is private.

- We'll keep your information private as required by law.
- We'll use the information on this form only to see if you qualify for medical assistance.

Persons 1, 2, and 3

Please tell us about all the people in your household. See page 2 for more information about who to include.

Start with yourself!

	Person 1 Yourself ⇩	Person 2 ⇩	Person 3 ⇩
First Name			
Middle Name			
Last Name			
Maiden Name			
What is this person's relationship to you?	*Self*		
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?		☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.			
Does this person have income?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
In the past year did this person (Check all that apply)	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a 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			
Social Security #			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, skip to Section D on page 9.		
Has this person lived in a state other than Kansas in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when and where?			
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?	/ /	/ /	/ /
How many babies are expected?			

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Does this person have a guardian or conservator?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is their name?			
U.S. citizen?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, complete Section C on page 8.		
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Has this person delivered a baby in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help paying medical bills from the last 3 months? If yes, please see additional questions in Section B on page 8.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a disability that will last at least 12 months or result in death?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help with nursing home costs or in-home care?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person live with at least one child under the age of 19 and are they the main person taking care of this child?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
This person's Mother's Full Name (only answer for children)	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:
This person's Father's Full Name (only answer for children)	First: Middle: Last:	First: Middle: Last:	First: Middle: Last:

Persons 1, 2, and 3 (continued)

Please continue to answer questions about Yourself, Person 2 and Person 3. Write their names on the first line.

	Person 1 Yourself	Person 2	Person 3
First and Last Name			
Federal Income Tax Information We have some questions about how you plan to file your taxes. Answer these questions based on your current situation.			
Based on your current situation, does this person plan to file a federal income tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If yes, please answer questions 1 – 3. If no, please skip to question 3		
1. Will this person file jointly with a spouse?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse			
2. Does this person have any dependents on their tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list name(s) of dependents			
3. Is this person claimed as a dependent on someone else's tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list the name of the tax filer			
How is this person related to the tax filer?			
Answer the following for persons age 26 or younger			
Did this person have insurance through a job and lose it within the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, end date and reason			
Is this person a full-time student?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Was this person in Kansas foster care at the time of their 18th birthday?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a parent living outside the home?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

If there is no one else in your home, skip to Section B at the bottom of page 8.

Persons 4, 5, and 6

Please answer questions about Persons 4, 5, and 6 in your household. If you have more people to add, please attach another sheet of paper and send it with your application.

	Person 4	Person 5	Person 6
First Name			
Middle Name			
Last Name			
Maiden Name			
What is this person's relationship to you?	*Self*		
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	/ /	/ /	/ /
Marital Status	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed	☐ Never Married ☐ Married ☐ Common-Law ☐ Divorced ☐ Separated ☐ Widowed
Does this person live at the same address as you?		☐ No ☐ Yes	☐ No ☐ Yes
If no, list address.			
Does this person have income?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
In the past year did this person (Check all that apply)	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working less hours ☐ None of these
We need Social Security Numbers (SSNs) for everyone applying for medical assistance. A SSN is optional for people not applying for medical assistance, but providing a 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			
Social Security #			
Is this person applying for medical assistance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		If no, skip to Section D on page 9.	
Has this person lived in a state other than Kansas in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, when and where?			
Pregnant?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is the expected due date?	/ /	/ /	/ /
How many babies are expected?			

Persons 4, 5, and 6 (continued)

Please continue to answer questions about Person 4, 5, and 6. Write their names on the first line.

	Person 4	Person 5	Person 6
First and Last Name			
Does this person have a guardian or conservator?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is their name?			
U.S. citizen?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, complete Section C on page 8.		
Race (optional) Check all that apply	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other	☐ White ☐ Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese ☐ Other Asian ☐ Asian Indian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other
Ethnicity (optional) If Hispanic/Latino ethnicity, check all that apply	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other	☐ Mexican ☐ Puerto Rican ☐ Mexican American Chicano/a ☐ Cuban ☐ Other
Has this person delivered a baby in the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Did this person have emergency care in the last 3 months to save life, organs, or bodily function?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help paying medical bills from the last 3 months? If yes, please see additional questions in Section B on page 8.	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a disability that will last at least 12 months or result in death?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person need help with nursing home costs or in-home care?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person live with at least one child under the age of 19 and are they the main person taking care of this child?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
This person's Mother's Full Name (only answer for children)	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:	First: Middle: Last: Maiden:
This person's Father's Full Name (only answer for children)	First: Middle: Last:	First: Middle: Last:	First: Middle: Last:

Persons 4, 5, and 6 (continued)

Please continue to answer questions about Person 4, 5, and 6. Write their names on the first line.

	Person 4	Person 5	Person 6
First and Last Name			
Federal Income Tax Information We have some questions about how you plan to file your taxes. Answer these questions based on your current situation.			
Based on your current situation, does this person plan to file a federal income tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If yes, please answer questions 1 – 3. If no, please skip to question 3		
1. Will this person file jointly with a spouse?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse			
2. Does this person have any dependents on their tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list name(s) of dependents			
3. Is this person claimed as a dependent on someone else's tax return?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list the name of the tax filer			
How is this person related to the tax filer?			
Answer the following for persons age 26 or younger			
Did this person have insurance through a job and lose it within the last 3 months?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, end date and reason			
Is this person a full-time student?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Was this person in Kansas foster care at the time of their 18th birthday?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Does this person have a parent living outside the home?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

B. Help with medical bills in the past 3 months

If you have requested help paying medical bills in the past 3 months, please answer these questions.	
Have there been any changes in the household during the last 3 months? (People moving in or out)	☐ No ☐ Yes
If yes, tell us about the household changes:	
Have there been any changes in the household income during the last 3 months?	☐ No ☐ Yes
If yes, tell us about the income changes:	

C. Immigration Status

Please provide immigration status for everyone applying who is NOT a U.S. citizen.
(Please note: Applying for KanCare medical assistance does not affect your immigration status.)

Name (First, Middle, Last)	Document Type	Immigration number	Immigration status

D. Tell Us About Jobs and Other Household Income

Does anyone in your household have a job? ☐ No ☐ Yes If yes, answer the questions below.

	Job 1	Job 2	Job 3	Job 4
Worker's Name				
Company Name				
Company Address				
Company Phone				
Start Date	/ /	/ /	/ /	/ /
How many hours working per week?				
Gross salary or hourly wage	$	$	$	$
How often are they paid?				
Date of next paycheck?	/ /	/ /	/ /	/ /
Do any of these jobs include tips, commissions or bonuses? If yes, answer the questions below.				
	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What type?				
What is the usual amount? (before deductions)	$	$	$	$
How often?				

Is anyone in your household self-employed? ☐ No ☐ Yes If yes, answer the questions below.
Self-employed means this person is their own boss. This includes odd jobs, childcare, lawn mowing, snow removal, cosmetic sales, rental income, etc, even if it is not your primary job.

	Self-employed 1	Self-employed 2	Self-employed 3	Self-employed 4
Self-employed person's Name				
Business Name				
What type of business is it?				
When did the business start?				
Were taxes filed on this income last year?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	If no, skip to Estimated Monthly Income			
What IRS form did you file for this income? (Check all that apply)	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other ________	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other ________	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other ________	☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F ☐ 4797 ☐ 1065 ☐ 1120S ☐ Schedule K ☐ Other ________
Reported Annual Gross Income	$	$	$	$
Reported Annual Gross Expenses	$	$	$	$
Estimated Monthly Income: (before expenses)	$	$	$	$
Monthly expenses	$	$	$	$

Predictable Changes in income: Do you have predictable income changes (up or down) 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 ☐ Yes If yes, please answer the questions below.

	Income 1	Income 2	Income 3	Income 4
Name of Person:				
Type of income:				
Total Income This Year:	$	$	$	$
Total Income Next Year	$	$	$	$

Does anyone in your household have income from somewhere other than work?
Examples: Social Security, VA Pension, unemployment, tribal income from gaming, college work study, or payments from a trust

☐ No ☐ Yes If yes, please answer the questions below.

	Income 1	Income 2	Income 3	Income 4
Who is the income for:				
What type of income?				
Who pays this income?				
How much?	$	$	$	$
How often?				

Does your household have any other income? ☐ No ☐ Yes If yes, please answer the questions below.

Note: You are not required to tell us about some kinds of income (such as SSI, Veteran's Payments, Child Support and tribal income obtained from natural resources, designated Indian trust land, or sales of items with cultural significance). Do you have any of these types? ☐ No ☐ Yes *You do not need to complete the section below for these types of income.*

	Income 1	Income 2	Income 3	Income 4
Who gives the money?				
Who is it given to?				
How much is given?				
How often is it given?				

Deductions: Check all that apply and give the amount and how often. These are things that can be deducted on a federal income tax return. Telling us about them could make the cost of medical assistance lower. Do not include any deduction related to self-employment.

	Deduction 1	Deduction 2	Deduction 3
Name of person with deduction			
What type of deduction? (alimony, student loan interest, etc)			
How much?	$	$	$
How often?			

E. Tell us about your Family's Health Insurance

Answer these questions for everyone who has health insurance now or had it within the last 3 months. If you do not know an answer, write 'unknown.'

Health Insurance Policy Information			
	Person 1	Person 2	Person 3
First and Last Name			
Does this person have other health insurance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ended	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage Check all that apply	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____
	Person 4	Person 5	Person 6
First and Last Name			
Does this person have other health insurance?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Policyholder's name			
Policyholder's SSN			
Insurance Company Name			
Insurance Company Address			
Date Began	/ /	/ /	/ /
Date Ended	/ /	/ /	/ /
Policy #			
Group #			
Type of Coverage	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____	☐ Catastrophic Only ☐ Dental ☐ Doctor ☐ Hospital ☐ Long Term Care ☐ Medicare Supplement ☐ Prescription ☐ Vision ☐ Other _____
If anyone's insurance ended in the last 3 months, please tell us why.			

Health Coverage From Jobs

You only need to answer these questions if someone in the household is eligible for health coverage from a job and the household income is MORE than the levels listed on Helpful Hints flyer (enclosed)
Attach a copy of this page for each job that offers coverage. Tell us about the **job** that offers coverage.

EMPLOYEE Information

Employee Name		Employee SSN	

EMPLOYER Information

Employer Name		Employer Identification Number (EIN)	
Employer Address		Employer Phone Number	
City, State, 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?

☐ No (Stop here and go to the next page)

☐ Yes (Please answer questions below)

If you're in a waiting period or probationary period, when can you enroll in coverage?	/ /

List the names of anyone else who is eligible for coverage from this job.

Name:		Name:		Name:	

Tell us about the health plan offered by the employer.

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

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 discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

What change will the employer make for the new year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See above question.)

How much will the employee have to pay in premiums for that plan?	$
How often?	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
Date of change (mm/dd/yyyy):	/ /

*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

F. American Indian or Alaska Native

Complete this page if you or family members are American Indian or Alaska Native.

Tell us about your American Indian or Alaska Native family member(s)			
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer these questions to make sure you and your family get the most help possible. Note: If you have more people to include, make a copy of this page and attach.			
	AI/AN Person 1	AI/AN Person 2	AI/AN Person 3
First and Last Name			
Member of a federally recognized tribe? If yes, give the name of the tribe.	☐ No ☐ Yes _____	☐ No ☐ Yes _____	☐ No ☐ Yes _____
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program or through a referral from one of these programs?	☐ No ☐ Yes If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? ☐ No ☐ Yes	☐ No ☐ Yes If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? ☐ No ☐ Yes	☐ No ☐ Yes If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs? ☐ No ☐ Yes
Certain money received may not be counted for Medicaid or CHIP. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How Often? _____	$ _____ How Often? _____	$ _____ How Often? _____

G. Choose Someone to Help You With Your Medical Assistance Case

You can name a person to help you with your medical assistance case. You can choose either a "Medical Representative" or a "Facilitator."

Medical Representative is a person who can sign your application, answer questions for you, and use your medical assistance card for you. We will share information with this person. This person will get copies of letters sent to you about your case. This person is responsible for completing your review each year and for telling us about changes in your situation. The Medical Representative can be a relative, neighbor, friend, or other person you trust. You may not name someone who is trying to collect a medical debt against you.

Facilitator is a person who can help you fill out your application and help you through the application process. We will be able to share information with this person. This person will get copies of letters sent to you about your application. After your application is processed, this person is not connected to your case. A facilitator can be someone such as a relative, neighbor, friend, medical office staff, or community organization employee.

I want to appoint the following person to help me.

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, etc)					
I appoint the above named person to be my ☐ Medical Representative, or ☐ Facilitator.					
Signature		Date			
Witness signatures are required if the signature above is made with a mark.					
Witness		Date			
Witness		Date			

Choose Your Health Plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please review the Extra Services Highlights flyer and choose your 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. For more information about these plans, visit www.KanCare.ks.gov

Note: For persons who are not eligible for a KanCare plan, information about coverage and services will be sent separately.

Amerigroup RealSolutions in healthcare ☐ Sunflower State Health Plan ☐ UnitedHealthcare ☐

H. Signature Page

You must sign and date this form before you send it back. **If this form is not signed, it will be returned to you.** This will cause a delay in processing your application. **Read the information below. Sign and Date.**

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 Children's Health Insurance Program (CHIP) premium each month if I qualify for that program. The premium may be as little as $0 or as much as $50 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, or managed care organizations for covered medical and other health services furnished to those for whom I am applying who are 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, KDADS, or other benefit programs, any information including financial and other confidential information necessary to establish my eligibility.

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.

Signature of Applicant (required) Date

Signature of Other Adult Applying Date

Signature of First Witness (if "X" is used) Date

Signature of Second Witness (if "X" is used) Date

Signature of Medical Representative (if applicable) Date

For help completing this application, call toll free: **1-800-792-4884**

FOR AGENCY USE ONLY:

Would you like to register to vote today?

No _____ Yes _____ Already registered _____

Information You May Have to Provide

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.

Proof of Income

If you are reporting that you have a job
We may need copies of your paystubs for the last 30 days, or a statement from your employer with your gross income (before deductions.)

If you are reporting that you are self-employed
You must send your most recent personal and business income tax returns, including all pages and attachments.

If you are reporting that you have other income
We may need a copy of the check or benefit letter that shows the amount of income you get and how often you get the payment.

If you have unpaid medical bills from the past 3 months and would like help
We may need copies of all paystubs or checks your family has received in the past 3 months.

Proof of Health Insurance

If you are reporting that someone in the household has other health insurance
You must send a copy of the front and back of your health insurance card.

Mail your signed application form to:

KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738

or Fax it to: 1-800-498-1255

✓ Did you remember to:

- ☐ Fill everything out?
- ☐ Tell us about everyone in your family and household, even if they don't need medical assistance?
- ☐ Sign this application on page 15?

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: KS-14-0012-MC4	**STATE:** Kansas

Through October 31, 2015, the state is using an interim online alternative single streamlined application. After October 31, 2015, the state will use a revised online 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.