MEMORANDUM OF UNDERSTANDING

I. INTRODUCTION

In November of 2019, Loud Light, Demos, the ACLU, and the ACLU of Kansas reached out to Kansas officials to express concern about the State's compliance with the National Voter Registration Act, 52 U.S.C. § 20501 *et. seq.* Governor Kelly's office and the Kansas Department of Health and Environment ("the Agency" or "KDHE") immediately recognized the opportunity to improve KDHE's voter registration services and began to work collaboratively with Loud Light and its counsel (Demos, ACLU and ACLU-KS, or "Counsel") to improve its policies and procedures.

This document details improvements to voter registration services – both improvements that are in process as well as already completed – and in so doing resolves Loud Light's concerns without the need for litigation. In consideration of Loud Light's agreement not to sue during its term and the waiver of any claim for attorneys' fees or costs incurred in connection with the negotiation, implementation, and monitoring of this Memorandum of Understanding ("MOU"), KDHE and the Governor agree to implement and maintain the procedures and practices outlined in this MOU. Provided, however, that nothing in this MOU shall be construed, in the event of a breach of this MOU by KDHE or the Governor, to prevent Loud Light from bringing a lawsuit pursuant to Section 7 of the NVRA, 52 U.S.C. § 20506 or Kan. Stat. Ann. § 25-2303(c)-(e), or any other applicable federal or state law; or to prevent Loud Light from pursuing attorneys' fees and costs as permitted by 52 U.S.C. § 20510 (provided that Loud Light does not seek any attorneys' fees for time spent negotiating, implementing, or monitoring this MOU as noted above).

II. DEFINITIONS

A. "Agency-specific voter registration application" means a Kansas voter registration application pre-coded in a manner that enables the form to be tracked back to a specific agency but cannot be easily identified as originating at that agency by a member of the public.

B. "Client" means any individual who is applying for or receiving public assistance benefits through or from KDHE.

C. "Completed," when referring to a voter registration application or other form, means filled out to some degree; it does not mean "finished," that each and every field contains the designated information, or that the information contained is sufficient for full processing.

D. "KDHE office" means any KDHE office through which individuals may apply for public assistance benefits, renew or recertify their public assistance benefits, or change their address with regard to the receipt of public assistance benefits.

E. "Covered transaction" means each time a client applies for public assistance benefits, renews or recertifies for public assistance benefits, or submits a change of address, whether in-person, or via the telephone, facsimile, mail, online or through other electronic means. 52 U.S.C. § 20506(a)(6)(A).

F. "KDHE" means the Kansas Department of Health and Environment and includes, without limitation, its offices, agents and employees.

G. " KDHE employee" or "frontline staff person" means an employee of KDHE who has responsibilities regarding Section 7 of the National Voter Registration Act, 52 U.S.C. § 20506, and/or state implementing statutes and regulations, Kan. Stat. Ann. § 25-2303(c)-(e), including, without limitation, those who are responsible for interacting with individuals regarding the provision of public assistance benefits, those who are responsible for interacting with clients at point of entry, the supervisors of such employees, and NVRA coordinators.

H. "Kansas Eligibility and Enforcement System" or "KEES" is the joint eligibility system shared by DCF and the Kansas Department of Health and Environment ("KDHE").

I. "KEES voter registration event" means an event that triggers an automatic mailing of a voter registration application and cover letter from the KEES system. This could be a single "yes" or blank response to a Voter Preference Question (VPQ) or it could be an aggregation of more than one response over the course of a single calendar week.

J. "Public assistance benefits" means those benefits available under various programs administered by KDHE, including, as non-limiting examples, the Kansas Medical Assistance Program ("KMAP" and more commonly known as Medicaid), the Children Health Insurance Program ("CHIP"), and the Kansas Family Medical Assistance Program (KFMAP").

K. "Transmittal forms" are cover sheets that are appended to any completed voter registration applications forwarded to elections officials that include the total number of voter registration applicants, the date of submission, and the name of the KDHE office making the submission.

L. "Voter Preference Question" or "VPQ" means the following question, mandated by Section 7 of the NVRA, 52 U.S.C. § 20506(a)(6)(B): "If you are not registered to vote where you live now, would you like to register to vote here today?"

M. "Voter registration application" means the written, mail-in voter registration application form described in Section 9 of the NVRA, 52 U.S.C. § 20508, or the equivalent Kansas voter registration application form.

N. "Voter registration information" means the VPQ or its equivalent and the related details about voter registration at KDHE that the NVRA requires KDHE to provide to its clients as part of a covered transaction.

III. REMEDIATION AND UPDATES TO KDHE VOTER REGISTRATION POLICIES

A. Remedial Mailings

As part of an agreed remediation strategy and to display good faith, the Kansas Department for Children and Families (DCF) mailed voter registration applications to 150,512 applicants and clients. While there were some applicants and clients who received public assistance from both DCF and KDHE who would be covered by DCF's remediation, there were some applicants and clients unique to KDHE, so KDHE sent additional 127,255 voter registration applications to unduplicated applicants and clients in September 2020.

B. KDHE Voter Registration Policies

KDHE has updated its official voter registration policies as outlined in the Medical KEESM at Section 1731 and Kansas Family Medical Assistance Manual at Section 1603 to reflect the updated or clarified procedures described below, including, *inter alia*, the inclusion of the Voter Preference Question as part of the benefit application forms; the federally compliant policy for treating a blank response to a Voter Preference Question as requiring the Agency to send a voter registration application; the Agency's obligation to provide the same level of assistance to clients completing voter registration forms as the Agency provides to clients completing the Agency's benefits forms; the obligation to provide voter registration services in Spanish and any other language later required by law; and the obligation to transmit completed voter registration applications to county elections officials within five days of receipt from clients.

The revised policy is attached to this MOU as Exhibit A. This policy guidance may not be altered during the term of this MOU without the written consent of Counsel.

IV. INCORPORATION OF VOTER REGISTRATION INFORMATION INTO BENEFITS DOCUMENTS

A. *Paper forms*. KDHE has modified its benefit applications and renewal forms to include voter registration information in the body of each form so that a separate voter preference form is no longer necessary. Samples of each of these forms are attached to this MOU as Exhibit B. None of these forms may be altered during the term of this MOU in a way that materially affects the voter registration portions of the form without the written consent of Counsel. Changes that may be deemed to materially affect the voter registration portion include placement of the voter registration text or changes to the wording or the size of the text. KDHE staff will

send all relevant proposed changes to Counsel, and Counsel will provide a decisive response within 30 days; a lack of a decisive response from Counsel shall be interpreted as assent to the proposed change.

B. *Online applications*. Within six months of the execution date of this MOU, clients who select "yes" to the VPQ will be provided with a link to Kansas' online voter registration system managed by the Kansas Department of Revenue ("KDOR"); and also given the option to check a box to indicate they would like to receive a voter registration application by mail. The KEES system will mail a voter registration application to any client who checks such a box within the time period set forth in Section VI.D below. This link will be accompanied by language informing the applicant that they must have a driver's license or state ID on file with KDOR in order to use the online voter registration system, and that if they prefer they may contact the Agency to have a paper voter registration application mailed to them, along with means of contact including a phone number and email.

If and when KDOR expands its system to be usable by Kansas residents without a Kansas driver's license or state ID on file, KDHE will provide a link to this improved system and remove the qualifying language above. KDHE shall confirm that this link (provided by KDOR) enables KDOR to track the number of applicants the Agency refers to KDOR's voter registration portal and will do so within three months of the KDOR update, if possible.

V. AGENCY-SPECIFIC VOTER REGISTRATION APPLICATIONS

KDHE has collaborated with the Secretary of State to create pre-coded voter registration applications that identify the particular public assistance agency source of a voter registration application (here, KDHE) to enable monitoring of the efficacy of voter registration services provided by Kansas public assistance agencies, including KDHE. When available, KDHE shall use the coded forms in all of the Agency's voter registration services. The agency is working with the Sec. of State's staff to create a process to distribute the coded voter registration applications to KDHE clients.

The current voter registration application and general cover letter sent with such application are attached to this MOU as Exhibit C.

Regardless of any additional burdens on voter registration the State of Kansas or any department thereof attempts to enforce or enact, KDHE will respect the language and intent of the NVRA, 52 U.S.C. § 20504(c)(2)(b); 20505(a); 20507(a)(c); 20508(b), that no prospective voter shall be required to provide more than the minimum amount of information required for the state to properly register that person to vote, and KDHE will continue to perform its voter registration duties in the manner that is most consistent with this principle.

VI. PROCEDURES

A. *Maintenance and availability of voter registration materials.*

1. KDHE shall ensure that each KDHE office that handles public assistance benefits maintains a sufficient number of registration applications to fulfill its voter registration responsibilities, including voter registration applications in Spanish. As soon as the pre-coded voter registration applications as detailed in Section V are available, KDHE shall ensure that each KDHE office that handles public assistance benefits is provided with and begins using only agency-specific voter registration applications in English and Spanish to fulfill its voter registration responsibilities.

2. KDHE shall make available to each KDHE office that handles public assistance benefits hip-pocket guides for every eligibility worker that interacts with the public. The hip-pocket guide will serve to remind KDHE staff of their voter registration duties. The hip-pocket guide shall also be displayed as a poster in non-public areas of the office.

3. KDHE shall make available to each KDHE office that handles public assistance benefits signs, in English and Spanish, announcing that voter registration is available. If the KDHE NVRA Coordinator is notified or becomes aware that a particular KDHE office that handles public assistance benefits is not displaying a voter registration sign, the NVRA Coordinator shall send the office a sign and request that the office display it.

4. The current versions of the hip-pocket guide and voter registration posters are attached to this MOU as Exhibit D. Future versions of the poster will include language informing readers they may "see staff for assistance."

B. *KDHE staff procedures*

1. *Distribution of voter registration materials, in general.* KDHE staff shall distribute a voter registration application with each application for public assistance and with each recertification or change of address related to such assistance, except in cases where a client declines in writing by marking "no" in response to the Voter Preference Question. Voter registration applications shall be available in each KDHE office that handles public assistance benefits to members of the public upon request.

2. *Application and recertification procedures*

    a. During each in-person interaction for initial application or recertification, the eligibility staff person will review the client's

response to the Voter Preference Question contained in the benefits form.

i. If the client has checked "yes" on the VPQ that they wish to register to vote, or has left that section blank, the worker will:

a) Provide a voter registration application, which should be agency-specific once the pre-coded voter registration applications detailed in Section V become available; and

b) Encourage the client to fill out the voter registration application immediately. The worker will provide the same level of assistance in filling out the voter registration application that the worker would provide with the agency's other forms. If the client prefers not to fill out the voter registration application immediately, the worker will advise them they may take a mail-in form home.

ii. If the client has checked "no" on the VPQ, KDHE shall take no further action except to maintain the benefits application form with the VPQ for at least two years as required in Section VI.G below.

b. During each remote interaction for initial application or recertification, the KDHE eligibility staff person will review the client's response to the Voter Preference Question contained in the online application. If the client checks yes to the VPQ or leaves it blank, the KDHE eligibility staff person shall inform the client that assistance in filling out a voter registration application is available.

3. *Change of address.* The Agency will mail a voter registration application and cover letter, attached to this MOU as Exhibit C, to any client who reports a change of address. The change of address call script is attached to this MOU as Exhibit E.

4. *Equal assistance.* Frontline staff persons shall respond to any questions from the client, examine the client's voter registration application for basic completeness and signature, and ask the client to complete any piece that is obviously missing. Staff must be familiar with basic voter registration eligibility requirements in order to perform this function.

C. *Joint eligibility system (KEES) upgrades.* DCF and KDHE recently upgraded their joint eligibility system, KEES, incorporating several changes. As part of any covered transaction conducted online, clients who answer "yes" to the VPQ or leave it blank will receive a voter registration application in the mail. The system will automatically mail the voter registration application and cover letter attached to this MOU as Exhibit C.

To reduce confusion among KDHE's clientele and enhance the efficient use of public resources, when any client conducts multiple covered transactions within the same week (defined as seven calendar days), either within KDHE or across both DCF and KDHE, the system will aggregate these transactions such that if the client answered yes to the VPQ or left it blank during any of these transactions, the system will automatically mail the client only one voter registration application and cover letter. Answering no at any point during the week to the VPQ does not override a yes or blank answer during the same week; clients who answer yes or leave the VPQ blank at any point in the week will be sent voter registration materials. KDHE will continue to prioritize distributing voter registration applications in-person as part of any in-person transaction.

When a voter registration application is provided electronically as part of a computer-based transaction, an electronic explanatory notice regarding the availability of assistance shall also be provided. For example, language shall be available on a web portal accompanying a link to voter registration opportunities.

D. *Transmittal of voter registration applications.* KDHE employees shall transmit all completed voter registration applications collected by the agency within five days of receipt as required by Kan. Stat. Ann. § 25-2309(e). Pursuant to 52 U.S.C. § 20507(a)(1)(C), voter registration applications collected by KDHE at any time up to the official close of voter registration for any given federal election shall be deemed timely and, when transmitted according to the procedure above, shall be treated as a voter registration application filed with the Kansas Secretary of State's office in advance of the deadline. KDHE shall transmit all applications to the Kansas Secretary of State's office within five days, regardless of completeness.

The voter registration applications transmitted to elections officials shall be accompanied by a cover letter/transmittal form that includes the total number of voter registration applicants, the date of submission, and the name of the KDHE office making the submission. The KDHE employee who conducts the transmission shall make their best effort to confirm receipt with the Kansas Secretary of State's office. A copy of the cover letter/transmittal form shall be sent to the KDHE NVRA Coordinator by the 10th of the month following the month of the submission.

E. *Remedial action.* If a KDHE employee determines, at any point, that a client did not receive a voter registration application as required under Section 7 of the NVRA, Kansas implementing statutes and regulations, or this MOU, the

employee shall notify the KDHE NVRA Coordinator immediately. Within five days of receiving such notice, the employee or the KDHE NVRA Coordinator shall send a remedial mailing to the client and enclose a voter registration application and explanatory notice.

F. *Maintenance of Voter Preference Question responses.* KDHE shall maintain all responses to the VPQ for a minimum of two years.

VII. STAFFING

A. *KDHE NVRA Coordinator*

KDHE has designated and shall continue to maintain a "KDHE NVRA Coordinator" to ensure implementation of voter registration services within KDHE, to monitor compliance with Section 7 of the NVRA and this MOU statewide, and to assist KDHE offices that handle public assistance benefits to identify and resolve problems as they arise. This need not be a full-time position or require the hiring of new/additional staff. The KDHE NVRA Coordinator's responsibilities shall include:

1. Familiarity with all KDHE voter registration requirements, procedures, and materials such that they are qualified and prepared to assist agency personnel with questions or challenges related to the agency's administration of NVRA-compliant voter registration services;

2. Coordinating and overseeing compliance with the requirements of Section 7 of the NVRA, Kansas's implementing statutes and regulations, and the provisions of this MOU, including requirements related to supplies, computer processes, training, procedures, oversight, and reporting, as detailed in Sections VI and VIII-IX of this MOU;

3. Collecting and analyzing office-level voter registration data, and taking any corrective actions required, per Section IX of this MOU.

4. Once per year, confirming with agency staff that all KDHE offices that handle public assistance benefits across the state are displaying posters advising the public of the right to register to vote at that site and that each relevant staffer has a hip-pocket guide as referenced in Section VI.2 above; and responding to any notification that signs or guides are lacking in a particular KDHE office by sending that office a new sign and requesting that the office display it or new guides for staff; and

5. Providing every KDHE office that handles public assistance benefits with a complete list of voter registration deadlines for federal elections for the coming year by December 31 of each year and distributing promptly any

supplemental lists of additional registration deadlines for federal elections received from the Secretary of State throughout the year.

VIII. TRAINING

A. *Training Materials*

1. KDHE has updated its existing online NVRA training module in consultation with Counsel. The training module reflects the requirements of the NVRA, Kansas's implementing statutes and regulations, and this MOU. Screen shots of the updated training module are attached to this MOU as Exhibit F.

2. The updated training module has been made available to KDHE staff as of August 2020, and it will be continuously available on KDHE's internal computer system or network so that any staff person may review it at any time. Any supervisor may require a member of their staff to review it if the supervisor determines that the staff member is not performing their NVRA obligations satisfactorily.

B. *Training Program*

1. Each KDHE NVRA Coordinator, KDHE staff who handle public assistance benefit applications and renewals and interact with the public concerning such applications and renewals, and their supervisors will be required to complete NVRA training annually.

2. Each KDHE staff person identified in Subsection B.1 above shall be required to view the training within forty-five days of hire or before their interaction with clients applying for public assistance, whichever is earlier, measured from the employee's start date. Each KDHE employee's supervisor will be notified when that employee has completed the training.

3. KDHE shall maintain a record of each KDHE employee's history of completing the required NVRA training.

4. In addition to the NVRA trainings referenced above, all KDHE staff identified in Subsection B.1 above will receive training on the use of the Agency's telephone translation service so that staff members are prepared to provide voter registration and other services in languages other than English.

IX. OVERSIGHT

A. KDHE shall continue to track the following information by month:

1. The number of covered transactions by type (application, renewal, recertification or change of address), broken down into online versus paper, as generated by KEES;
2. The number of KEES voter registration events
3. The number of completed voter registration applications transmitted to the Kansas Secretary of State. (This will continue to be tracked manually.)

B. Each month, the KDHE NVRA Coordinator shall analyze the data collected by comparing, for each KDHE office that handles public assistance benefit applications and renewals, the number of voter registration applications transmitted to elections officials (and the number of online referrals referenced in Section IX.C above, when available) during the month at issue with the office's prior monthly numbers.

Each quarter, the KDHE NVRA Coordinator shall analyze the data collected by comparing, for each KDHE office that handles public assistance benefit applications and renewals, the number of voter registration applications transmitted to elections officials (and the number of online referrals referenced in Section IX.C above, when available) during the quarter at issue with the number of covered transactions that occurred during the same quarter, with the prior quarterly numbers

The KDHE NVRA Coordinator shall review, follow up on and/or investigate problems in KDHE offices that handle public assistance benefit applications and renewals. Potential problems requiring investigation or review include, but are not limited to: (i) Low overall numbers of voter registration applications for particular offices that are sustained over two or more months; (ii) significant declines in the ratio between voter registration applications (or online referrals, if available) and covered transactions that are sustained over two or more quarters; and (iii) any complaint from the public or a client regarding the provision of voter registration at applicable KDHE offices or by applicable KDHE eligibility staff.

Where a potential compliance problem is identified for an office, the KDHE NVRA Coordinator shall contact the appropriate KDHE supervisor to investigate the cause.

C. Site visits

Based on follow-up reports in quarterly updates, if Counsel identifies a consistent and significant concern with a particular KDHE office that handles public assistance benefit applications or renewals, Counsel may request the KDHE NVRA Coordinators or other NVRA-trained KDHE staff person(s) conduct a site visit at said KDHE office. The site visit shall include conversations and observations related to the concerns identified by Counsel, and may include brief conversations with 5-8 clients, observation of lobbies to locate voter registration forms and posters, and conversations with staff about the voter registration

process, assistance offered to clients, and the transmittal process for completed voter registration forms. At Counsel's request, site-checks must include engagement with Spanish-speaking clients to ensure services are adequately provided in Spanish. Counsel may request up to 3 NVRA site visits per year.

Counsel may also request investigation or follow up with respect to any potential Agency-wide issue(s) raised by their review of any quarterly report (QR1), and KDHE shall investigate and communicate the results to Counsel in the following quarterly report (QR2), or the subsequent quarterly report (QR3) if the request is not communicated to KDHE within a month of receipt of QR1.

D. *Scheduled on-site reviews.* KDHE shall monitor applicable KDHE offices' compliance with Section 7 of the NVRA by conducting annual site visits at applicable KDHE offices across the state.

1. This process will include talking with clients to ascertain whether they received the proper voter registration services and should include engagement with Spanish-speaking clients wherever possible – when such clients are present in the office during the course of the review.

2. Deficiencies found by KDHE during the review shall be reported to the KDHE NVRA Coordinator who will develop and implement a corrective action plan related to NVRA compliance in that KDHE office.

E. *Corrective Action.* KDHE shall ensure that any complaints made by the public regarding the provision of voter registration by KDHE offices shall be forwarded to the affected KDHE office and also forwarded to the KDHE NVRA Coordinator.

X. INCORPORATING VOTER REGISTRATION SERVICES INTO FUTURE GRANT AGREEMENTS

Any grant agreements or contracts KDHE enters into with private entities that assist potential clients with public benefits applications or perform any public benefits eligibility determination services during the course of this MOU shall include provisions requiring these entities to offer voter registration services, including by ensuring proper distribution of voter registration applications and offering equal assistance as described in Section VI.

XI. REPORTING TO COUNSEL

A. *Quarterly Reporting.* On or before the fifteenth day of the month in January, April, July and October after this MOU is executed and thereafter until the expiration of this MOU, KDHE shall provide the below-listed items for the three months immediately preceding the reporting month to Counsel. If the fifteenth

day of the month falls on a weekend or holiday, these reports shall be provided on the next business day thereafter.

1. A report in Excel spreadsheet format or a format that can be easily converted to Excel containing the following data, broken down by month:
   a. The number of covered transactions by type (application, recertification, or change of address), broken down into online or other methods;
   b. The number of KEES voter registration events;
   c. The number of completed voter registration applications transmitted to the appropriate election authority;
   d. The number of "yes," "no," and blank answers to the VPQ; and
   e. The number of online referrals, if KDOR makes this information available to KDHE.

2. Any investigations or corrective actions undertaken during the preceding quarter, as detailed in Section IX;

3. The number of staff who completed NVRA trainings that quarter; the cumulative number who have completed trainings for the calendar year; and the total number of staff required to complete the trainings under the terms of this MOU;

4. All evaluation reports pursuant to Section IX.C&D that note any deficiencies;

5. In the first quarterly report, which shall be January 15, 2022, the information listed below, which also shall be reported upon any change in its content:
   a. The identity of the KDHE NVRA Coordinator; and
   b. Any other checklists, worksheets, or documents related to Agency compliance with Section 7 of the NVRA.

B. All reporting to Counsel shall be electronic and communicated by email, unless otherwise agreed to by the parties to this MOU. Reporting shall be Pamela Cataldo, Demos Paralegal & Field Investigator, at pcataldo@demos.org and Sarah Brannon, Managing Attorney, ACLU Voting Rights Project, at sbrannon@aclu.org unless and until Counsel informs KDHE directly in writing (including electronically via email) of a change in the person(s) who shall receive the reports and provides a new email address. All data should be reported in Microsoft Excel or a similar electronic, manipulatable format.

XII. TERM AND ENFORCEMENT

This MOU shall become effective on the date of execution and shall remain in effect until June 30, 2025.

The procedures and practices described in Sections III through XI above shall be implemented within 15 days of the execution of the MOU or at such other specific times as delineated herein, except for those which, as indicated, have already been put into practice; and shall remain in place through the term of this MOU.

If Counsel concludes that KDHE is in breach of this MOU, Counsel shall notify KDHE's General Counsel in writing of the asserted breach and identify and describe such alleged breach. KDHE shall then have sixty days to respond to the notice and take action to cure the asserted breach. If KDHE does not respond to the notice and take action to cure the asserted breach by the end of 60 days, Loud Light may file an action both under the NVRA and to enforce this MOU. If the breach is not cured within 60 days of the notice of breach – or 180 days if the cure requires a KEES systems change – notwithstanding the action taken, Loud Light may file an action both under the NVRA and to enforce this MOU.

XIII. EXECUTION IN COUNTERPARTS

This MOU may be executed in two or more counterparts, each of which shall constitute an original instrument and all of which together shall constitute one and the same MOU.

XIV. BINDING EFFECT

The persons signing this MOU represent that they have the authority to enter into this MOU on behalf of the respective parties they represent and that this MOU shall be binding upon the parties hereto.

Laura Kelly
Governor, State of Kansas

9.29.21
DATE

Lee A. Norman
Secretary,
Kansas Department of Health and Environment

10-1-21
DATE

Davis Hammet
President, Loud Light, Inc.

DATE

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Laura Kelly Governor, State of Kansas	DATE
Lee A. Norman Secretary, Kansas Department of Health and Environment	DATE
Davis Hammet President, Loud Light, Inc.	9/30/21 DATE

NVRA MOU

TABLE OF EXHIBITS

EXHIBIT #	DESCRIPTION	MOU SECTION & PAGE
A	Kansas Medicaid NVRA Policy – • Section 1731, Medical Kansas Economic and Employment Support Manual; • Section 1603, Kansas Family Medical Assistance Manual • Policy Directive 2020-09-01 – voter registration • KDHE Voter Registration Manual Process	III.B – p. 3
B	Sample Paper Kansas Medicaid Applications - Forms KC 1100 & KC1500 as updated	IV.A – p.3
C	September 2021 Voter Registration Application and generic cover letter	V – p. 4
D	KDHE Hip Pocket Guide	VI.A.4 – p. 5
E	Sample Change of Address Script	VI.B.3 – p. 6
F	KDHE NVRA Training	VIII.A.1 – p. 9

NVRA MOU – EXHIBIT A - KDHE Policy

1731 - Voter Registration - The National Voter Registration Act of 1995 requires voter registration to be available in public assistance offices. The Act also requires that anyone applying for or receiving public assistance, including Medicaid, be offered the opportunity to register to vote at the time of initial application, each eligibility review, and each report of a change of address. Each individual must be informed of this registration service and offered the same level of assistance in completing the voter registration form or declining the registration activity as the agency provides in completing it's own forms. The KC-1100, Medical Assistance application for Families with Children, and the KC-1500, Medical Assistance Application for the Elderly and Persons with Disabilities, offers everyone the opportunity to register to vote or to decline to register. Completion of the voter registration question on the application is not a condition of eligibility for assistance. An answer of "Yes", "No" or blank in the Voter Registration section has no bearing on case processing or eligibility. Those applying on-line are offered the opportunity to link to the Secretary of State's voter registration site. All those who answer "yes" or leave the voter registration section blank are to be mailed a voter registration application. This means that even if an individual does not complete this section of the application, the agency must provide the individual with a voter registration application. Voter Registration forms can be returned to KanCare and will be sent to the corresponding Secretary of State's Office within five (5) days of receipt.

1603 Voter Registration - The National Voter Registration Act of 1995 requires voter registration to be available in public assistance offices. The Act also requires that anyone applying for or receiving public assistance, including Medicaid, be offered the opportunity to register to vote at the time of initial application, each eligibility review, and each report of a change of address. Each individual must be informed of this registration service and offered assistance in completing the voter registration form or declining the registration activity. The KC1100, Medical Assistance Application for Families with Children and the KC1500, Medical Assistance Application for the Elderly and Persons with Disabilities offers everyone the opportunity to register to vote or to decline to register. Completion of the voter registration question is not a condition of eligibility for assistance. If an individual does not complete this section of the application, it is considered an indication of voter registration. An answer of "Yes", "No" or blank in the Voter Registration section has no bearing on case processing or eligibility. Those applying on-line are offered the opportunity to link to the Secretary of State's voter registration site. All those who answer "yes" are to be handed or mailed a voter registration application. Voter Registration forms can be returned to KanCare and will be sent to the corresponding Secretary of State's Office within five (5) days of receipt.

Kansas
Department of Health and Environment

Policy Directive 2020-09-01

Title: Voter Registration

Date: September 01, 2020

From: Erin Kelley, Senior Manager Policy

Program(s) impacted: All Medical Programs

The purpose of this document is to advise of changes to the Voter Registration policies. Effective September 1, 2020, the following changes will be implemented:

1. The KC-1100 and KC-1500 application forms contain a "voter preference question" inquiring as to whether the consumer wishes to register to vote. If a consumer checks yes or fails to indicate that they want to register to vote, KanCare will now assume the answer is "Yes" and provide the Voter Registration form to the consumer in person or have the form mailed.
2. The 15 Language Tag Line and the new Voter Registration Companion letter must be included in the voter registration mailing to the consumer.
3. If an address change request is processed, a Voter Registration form, Companion letter and 15 Language Tag Line must be sent to the consumer unless the consumer reported the change by phone and has specifically advised the agency at the time of change that this information need not be sent.
4. During a walk-in, if a consumer requests the Voter Registration form at that time instead of mailed, staff must accommodate the request.
5. If at any point the consumer wishes to have the Voter Registration form sent to them, staff must accommodate the request by following their departments business process.
6. If a consumer indicates they need help filling out the Voter Registration form, staff shall provide the client assistance completing the form, as indicated on the top of the Voter Registration Application. Specific questions regarding Voter Registration, as it relates to a particular consumer, will need to be directed to the Office of the Secretary of State, 1-800-262-8683.
7. In the future, system changes will be added to KEES to allow the Voter Registration packets to be mailed with all reviews and address changes – allowing for more automated Voter Registration processes. The Companion letter will also be added to KEES for staff's use. Additional information regarding these process changes will be provided with the KEES release notes corresponding with the implementation of the system changes.

KFMAM 1603 and Medical KEESM 1731 will also be updated to reflect this added information. A link to the Voter Registration form will be added to the Kansas Eligibility Policy website in the Appendix section under Miscellaneous: http://www.kssos.org/forms/elections/voterregistration.pdf

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff below.

Erin Kelley, Senior Manager – Erin Kelley@ks.gov
Kris Owensby-Smith, Elderly and Disabled Program Manager-Kristopher.OwensbySmith@ks.gov
Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov
Jerri Camargo, Family Medical Program Manager - Jerri.M.Camargo@ks.gov
Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov

KDHE Voter Registration Manual Process

- KDHE-DHCF must provide consumers the opportunity to register to vote as required by the National Voter Registration Act. This process is created based on Policy Directive 2020-09-01 and outlines how to send a Voter Registration Packet for applications, walk-ins, and in-state physical address changes effective request received **September 1, 2020**. The packets must be mailed within 7-days of the request. NOTE: Anytime we ask a consumer if they would like to register to vote, it is necessary to mention that their decision will not affect their benefits.

Database Tracking

- Staff will document the requests on a tracking spreadsheet and send to KDHE.VoterRegistration@ks.gov.
  - The spreadsheet data must include: Date Requested, Request Source (Phone, LTC Comm, MCO, Application, Walk-in, Other), KEES Case number, Case Name, Address (newest address), and Date Packet Mailed.

Application Request Received

- If the consumer checks yes or fails to indicate that they want to register to vote, KanCare will assume the answer is yes, and provide a Voter Registration Packet.
  - Registration Staff will complete the tracking spreadsheet and Email to Eileen.Bertels2@ks.gov and KDHE.VoterRegistration@ks.gov daily, at the beginning of the following day.
    - Please note that if KDHE eligibility staff register a new application, this spreadsheet must be completed and emailed at the end of the day.
  - The email must include in the subject line: **Voter Registration Data**

Address Change Request Received

- A request is received through a phone call
  - Call Center will inquire if a voter registration packet is needed.
    - Call Center Representatives will complete the tracking spreadsheet with the required data: Date Requested, Request Source (Phone), KEES Case number, Case Name, Address (newest address).
  - If KDHE eligibility staff receive the information during a call, then KDHE eligibility must complete the spreadsheet and emailed at the end of the day.
  - Call Center will email Eileen.Bertels2@ks.gov **and** KDHE.VoterRegistration@ks.gov daily, at the beginning of the following day.

- The email must include in the subject line: **Voter Registration Data**

☐ A request is received via returned mail, 3161**,** 2126, or any other method of written correspondence notifying of an address change.
- KanCare will send a Voter Registration Packet on every address change request received.
- KDHE Eligibility staff will complete the tracking spreadsheet with the required data and email to KDHE.VoterRegistration@ks.gov daily, at the end of the day.
- The email must include in the subject line: **Voter Registration Data**

☐ Request received through the MCO spreadsheet
- KanCare will send a Voter Registration Packet on every address change request received.
- KDHE Eligibility staff will complete the tracking spreadsheet with the required data and email to KDHE.VoterRegistration@ks.gov daily, at the end of the day.
- The email must include in the subject line: **Voter Registration Data**

Walk-In Request Received

☐ When a request is received via walk-in, KanCare will provide the consumer the Voter Registration packet.
- The agency will need to track the data received by completing the tracking spreadsheet with the required data and email to KDHE.VoterRegistration@ks.gov daily, at the end of the day, or individually as encountered
- The email must include in the subject line: **Voter Registration Data**

End of Process

NVRA MOU – EXHIBIT B - Applications

Families with Children
Medical Assistance Application

Apply faster online! Go to ApplyforKanCare.ks.gov.

This application is for families, children without disabilities, and pregnant women.
If you are applying for a child or adult with a disability or for someone who is elderly, use the ***Elderly and Persons with Disabilities*** *Medical Assistance Application*.

Make sure you:

1. **Answer** all questions on the application
2. **Sign** the application on page 30
3. **Include** any proof you want to send. You do not have to send any proof now. See page 31 for a list of proof we may need if we cannot obtain it on our own.
4. **Mail** your completed and signed application to:

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

   Or Fax to: 1-800-498-1255

Contents

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

By law, we must keep your information private. We will use your application information only to see if you qualify for medical assistance.

We have free interpreters if you need help in other languages.

العربية / ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافرلك بالمجان. اتصل برقم 1-800-792-4884 (رقم هاتف الصم والبكم: 1-800-792-4292).

မွန်မာ / BURMESE

သတိပြုရန် - အ ယ်၍ သင်သည် မြန်မာစ ား ို ပြောပါ ၊ ဘာသာစ ား အ ူအညီ၊ အခမဲ့၊ သင့်အတွ ် စီစဉ်ဆောင်ရွ ်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-792-4884** (TTY: **1-800-792-4292**) သို့ ခေါ်ဆိုပါ။

中文 / CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-792-4884 (**TTY: **1-800-792-4292)**。

فارسی / FARSI

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-792-4884 (TTY: 1-800-792-4292) تماس بگیرید.

FRANÇAIS / FRENCH

Attention: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-792-4884** (ATS : **1-800-792-4292).**

DEUTSCHE / GERMAN

Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-792-4884** (TTY: **1-800-792-4292**).

HMOOB / HMONG

Lus Ceev: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-792-4884** (TTY: **1-800-792-4292**).

日本語 / JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-792-4884** (TTY: **1-800-792-4292**) まで、お電話にてご連絡ください。

한국어 / KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-792-4884** (TTY: **1-800-792-4292**) 번으로 전화해 주십시오.

한국어 / LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-792-4884** (TTY: **1-800-792-4292**).

РУССКИЙ / RUSSIAN

Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-792-4884** (телетайп: **1-800-792-4292**).

ESPAÑOL / SPANISH

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-792-4884** (TTY: **1-800-792-4292**).

SWAHILI

Kumbuka: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu **1-800-792-4884** (TTY: **1-800-792-4292**).

TAGALOG

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-792-4884** (TTY: **1-800-792-4292**).

TIẾNG VIỆT / VIETNAMESE

Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-792-4884** (TTY: **1-800-792-4292**).

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For adults who need coverage:

Include these people *even if they aren't applying for health coverage themselves:*

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return, including any children over age 21 who are claimed on a parent's tax return. You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:

Include these people *even if they aren't applying for health coverage themselves:*

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

The paper clip means we may ask for proof later. Or you can send it now. See the list on page 31.

A Tell us about the primary applicant

The primary applicant is the person who needs medical assistance. If the person who needs medical assistance is a child, then the primary applicant is the child's parent or the head of household. Where you see "Yourself" and "You" that also means the primary applicant.

Primary applicant: Yourself *(or the parent or head of household if the person applying is a child)*

Your name

First name	Middle name	Last name

Other names used (such as maiden name)

Your contact information

Home address		**Mailing** address (if different from **Home** address)	
City	State	City	State
County	ZIP Code	County	ZIP Code

☐ Check here if you don't have a home address. You still need to give a mailing address.

Home phone	Work phone
___ ___ ___–___ ___ ___–___ ___ ___ ___	___ ___ ___–___ ___ ___–___ ___ ___ ___

▶ May we contact you by:	☐ Email	Email address:
	☐ Text	Cell phone number: ___ ___ ___–___ ___ ___–___ ___ ___ ___

What language do you **speak** at home?	What language do you **read and write** at home?

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

B Tell us about yourself and the people in your household

- Start with yourself (the primary applicant, or the parent or head of household if the person applying is a child).
- There is room on this application for 6 people. Pages 4–10 are for Persons 1, 2, 3. Pages 11–17 are for Persons 4, 5, 6.
- If more than 6 people are in your household, make copies of **pages 11–17** before you fill them out.

Use the copies to complete persons 7, 8, 9 and so on. Attach the copies to your application.

1: Yourself	Person 2	Person 3
Each person's name		
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
Is this person applying for medical assistance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is each person's relationship to you?		
Person 1 is my: ***Self***	Person 2 is my:	Person 3 is my:
Gender		
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)		
/ /	/ /	/ /
Marital status		
☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)
Does this person live at the same address as Person 1?		
Leave blank	☐ No ☐ Yes	☐ No ☐ Yes
	▶ **If no,** list address:	▶ **If no,** list address:

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B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 ***(continued)***	**Person 2** ***(continued)***	**Person 3** ***(continued)***
First and last name	First and last name	First and last name
In the past year did this person (check all that apply):		
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these
Is this person under 26?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** were they in Kansas foster care at the time of their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person under 23? **If yes,** answer the next 2 questions.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Are they a full-time student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Have they had insurance through a job **and** lost it within the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what was the end date and reason?		
End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /
Reason	Reason	Reason
We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. We use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are **not** applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. If you don't give your SSN, you can still apply.		
What is this person's Social Security Number?		
Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __

B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 ***(continued)***	**Person 2** ***(continued)***	**Person 3** ***(continued)***
First and last name	First and last name	First and last name
Is this person a U.S. citizen or U.S. national? **Must** answer if applying for medical assistance.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us this person's alien number and certificate number.		
Alien number (optional)	Alien number (optional)	Alien number (optional)
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
If this person is **not** a U.S. citizen or U.S. national, do they have eligible immigration status?		
☐ Yes	☐ Yes	☐ Yes
▶ **If yes,** tell us more about this person's immigration status.		
Document type	Document type	Document type
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
Card number or passport number	Card number or passport number	Card number or passport number
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
Other (category code or country where issued)	Other (category code or country where issued)	Other (category code or country where issued)
Has this person lived in the U.S. since 1996?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person, or is their spouse or parent, a veteran or an active duty member of the U.S. military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 *(continued)*	**Person 2** *(continued)*	**Person 3** *(continued)*
First and last name	First and last name	First and last name
What is this person's **race**? Check all that apply. *This question is optional. You do not have to answer.*		
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other
What is this person's **ethnicity**? If Hispanic or Latino ethnicity, check all that apply. *This question is optional. You do not have to answer.*		
☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other
Does anyone in your household have discharged, forgiven or canceled student loan debt after January 1, 2018?		
☐ No ☐ Yes **If yes,** complete the following.		
What year was it discharged, forgiven or canceled?		
How much was discharged, forgiven or canceled?		
$	$	$
Was it discharged, forgiven or canceled because of the permanent disability or death of the student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

B Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 *(continued)*	**Person 2** *(continued)*	**Person 3** *(continued)*
First and last name	First and last name	First and last name
Is this person pregnant?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how many babies are expected?		
▶ **If yes,** what is the expected due date? Estimate if unknown. (mm/dd/yyyy) *This question is optional. You do not have to answer.*		
/ /	/ /	/ /
Answer the next 5 questions **only** for persons applying for assistance. For any person not applying, go to "Section D: Federal income tax information" on **page 10**.		
If this person is applying, do they have a disability that will last at least 12 months or result in death?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying for in-home care or nursing home costs?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they incarcerated (in jail or detained)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** are they facing disposition of charges (waiting for the final outcome of an arrest or prosecution)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they live with, and are they the main person taking care of, at least one child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they a child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** please tell us the names of the child's parents:		
Parent 1 First, middle, and last name	Parent 1 First, middle, and last name	Parent 1 First, middle, and last name
Parent 2 First, middle, and last name	Parent 2 First, middle, and last name	Parent 2 First, middle, and last name

c Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July.

Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for Yourself, Person 2, and Person 3.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Answer the next 4 questions **only** for persons applying for assistance. For any person not applying, go to "Section D: Federal income tax information" on page 10.		
If this person is applying, did they deliver a baby in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, did they have emergency care in the last 3 months to save life, organs or bodily function?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying medical bills from the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, have they lived in a state other than Kansas in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

D Federal income tax information

Tell us how you and your household plan to file your taxes.
Continue to answer questions about Yourself, Person 2, and Person 3.

Person 1 ***(continued)***	**Person 2** ***(continued)***	**Person 3** ***(continued)***
First and last name	First and last name	First and last name
Based on their current situation, does this person plan to file a federal income tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** will this person file jointly with a spouse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse	**If yes,** name of spouse	**If yes,** name of spouse
▶ **If yes,** does this person have any dependents on their tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list names of dependents	**If yes,** list names of dependents	**If yes,** list names of dependents
Is this person claimed as a dependent on the tax return of someone who is **not** a household member?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, who **claims** Person 1 as a dependent on their tax return?	**If yes,** who **claims** Person 2 as a dependent on their tax return?	**If yes,** who **claims** Person 3 as a dependent on their tax return?
How is Person 1 related to the person who **claims** them? *For example, Person 1 is the **child** of the person who claims them.*	How is Person 2 related to the person who **claims** them? *For example, Person 2 is the **child** of the person who claims them.*	How is Person 3 related to the person who **claims** them? *For example, Person 3 is the **child** of the person who claims them.*

If you don't have more than 3 people in your household, go to "Section E: Tell us about changes in your household" on **page 18**.

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B Tell us about Persons 4, 5, and 6

Please answer questions about Person 4, Person 5, and Person 6 in your household. If you don't have more than 3 people in your household, go to "Section E: Tell us about changes in your household" on **page 18**.

Person 4	Person 5	Person 6
Each person's name		
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
Is this person applying for medical assistance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is each person's relationship to you?		
Person 4 is my:	Person 5 is my:	Person 6 is my:
Gender		
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)		
/ /	/ /	/ /
Marital status		
☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)
Does this person live at the same address as Person 1?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If no,** list address:	▶ **If no,** list address:	▶ **If no,** list address:

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
In the past year did this person (check all that apply):		
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these
Is this person under 26?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** were they in Kansas foster care at the time of their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person under 23? **If yes,** answer the next 2 questions.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Are they a full-time student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ Have they had insurance through a job **and** lost it within the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what was the end date and reason?		
End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /	End date (mm/dd/yyyy) / /
Reason	Reason	Reason

We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. We use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are **not** applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. If you don't give your SSN, you can still apply.

What is this person's Social Security Number?		
Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __

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B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5 *(continued)***	**Person 6 *(continued)***
First and last name	First and last name	First and last name
Is this person a U.S. citizen or U.S. national? **Must** answer if applying for medical assistance.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us this person's alien number and certificate number.		
Alien number (optional)	Alien number (optional)	Alien number (optional)
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
If this person is **not** a U.S. citizen or U.S. national, do they have eligible immigration status?		
☐ Yes	☐ Yes	☐ Yes
▶ **If yes,** tell us more about this person's immigration status.		
Document type	Document type	Document type
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
Card number or passport number	Card number or passport number	Card number or passport number
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
Other (category code or county where issued)	Other (category code or county where issued)	Other (category code or county where issued)
Has this person lived in the U.S. since 1996?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person, or is their spouse or parent, a veteran or an active duty member of the U.S. military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5 *(continued)***	**Person 6 *(continued)***
First and last name	First and last name	First and last name
What is this person's **race**? Check all that apply. *This question is optional. You do not have to answer.*		
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other
What is this person's **ethnicity**? If Hispanic or Latino ethnicity, check all that apply. *This question is optional. You do not have to answer.*		
☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other
Does anyone in your household have discharged, forgiven or canceled student loan debt after January 1, 2018?		
☐ No ☐ Yes **If yes,** complete the following.		
What year was it discharged, forgiven or canceled?		
How much was discharged, forgiven or canceled?		
$	$	$
Was it discharged, forgiven or canceled because of the permanent disability or death of the student?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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B Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
Is this person pregnant?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how many babies are expected?		
▶ **If yes,** what is the expected due date? Estimate if unknown. (mm/dd/yyyy) *This question is optional. You do not have to answer.*		
/ /	/ /	/ /
Answer the next 5 questions **only** for persons applying for assistance. For any person not applying, go to "D: Federal income tax information" on **page 17**.		
If this person is applying, do they have a disability that will last at least 12 months or result in death?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying for in-home care or nursing home costs?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they incarcerated (in jail or detained)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** are they facing disposition of charges (waiting for the final outcome of an arrest or prosecution)?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they live with, and are they the main person taking care of, at least one child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, are they a child under the age of 19?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** please tell us the names of the child's parents:		
Parent 1 First, middle, and last name	Parent 1 First, middle, and last name	Parent 1 First, middle, and last name
Parent 2 First, middle, and last name	Parent 2 First, middle, and last name	Parent 2 First, middle, and last name

c Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July.

Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for Person 4, Person 5, and Person 6.

Person 4 ***(continued)***	**Person 5** ***(continued)***	**Person 6** ***(continued)***
First and last name	First and last name	First and last name
Answer the next 4 questions **only** for persons applying for assistance. For any person not applying, go to "Section D: Federal income tax information" on **page 17**.		
If this person is applying, did they deliver a baby in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, did they have emergency care in the last 3 months to save life, organs or bodily function?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, do they need help paying medical bills from the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If this person is applying, have they lived in a state other than Kansas in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

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D Federal income tax information

Tell us how you and your household plan to file your taxes.
Continue to answer questions about Person 4, Person 5, and Person 6.

Person 4 *(continued)*	**Person 5** *(continued)*	**Person 6** *(continued)*
First and last name	First and last name	First and last name
Based on their current situation, does this person plan to file a federal income tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** will this person file jointly with a spouse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse	**If yes,** name of spouse	**If yes,** name of spouse
▶ **If yes,** does this person have any dependents on their tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list names of dependents	**If yes,** list names of dependents	**If yes,** list names of dependents
Is this person claimed as a dependent on the tax return of someone who is **not** a household member?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, who **claims** Person 4 as a dependent on their tax return?	**If yes,** who **claims** Person 5 as a dependent on their tax return?	**If yes,** who **claims** Person 6 as a dependent on their tax return?
How is Person 4 related to the person who **claims** them? *For example, Person 4 is the **child** of the person who claims them.*	How is Person 5 related to the person who **claims** them? *For example, Person 5 is the **child** of the person who claims them.*	How is Person 6 related to the person who **claims** them? *For example, Person 6 is the **child** of the person who claims them.*

E Tell us about changes in your household

Has your household **size** changed in the last 3 months because someone moved in or out?

☐ No ☐ Yes **If yes,** tell us about the **household** changes:

Has your household **income** changed in the last 3 months?

☐ No ☐ Yes **If yes,** tell us about the income changes:

F Tax deductions

Tell us about anything deducted on your federal income tax return, such as alimony, student loan interest, etc. This could help lower your cost for medical assistance. Do not include deductions related to self-employment. If you have more than 3 deductions, make a copy of this page before you fill it out. Attach the copy to your application.

Deduction #1	Deduction #2	Deduction #3
Name of person with deduction	Name of person with deduction	Name of person with deduction
Type of deduction	Type of deduction	Type of deduction
Amount $	Amount $	Amount $
How often?	How often?	How often?

G Jobs and other household income

If you need to tell us about more than 3 jobs in your household, make copies of **pages 18-19** before you fill them out. Attach the copies to your application.

Does anyone in your household have a job?

☐ No ☐ Yes **If yes,** tell us about **all** jobs of **all** household members.

Job #1	Job #2	Job #3
Worker's name	Worker's name	Worker's name
Company name	Company name	Company name
Company address	Company address	Company address
Company phone	Company phone	Company phone

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Job #1 *(continued)*	**Job #2** *(continued)*	**Job #3** *(continued)*
Worker's name	Worker's name	Worker's name
Income **before** any taxes or deductions are taken out:		
This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year	This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year	This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year
▶ What deductions are taken out of the gross pay before taxes? Check the box and tell us the amount:		
☐ Health Insurance (includes dental, vision, and accident) $	☐ Health Insurance (includes dental, vision, and accident) $	☐ Health Insurance (includes dental, vision, and accident) $
☐ Health Savings Accounts (HSAs) $	☐ Health Savings Accounts (HSAs) $	☐ Health Savings Accounts (HSAs) $
☐ Flexible Spending Accounts (FSAs) $	☐ Flexible Spending Accounts (FSAs) $	☐ Flexible Spending Accounts (FSAs) $
☐ Retirement Accounts (such as 401K or IRA) $	☐ Retirement Accounts (such as 401K or IRA) $	☐ Retirement Accounts (such as 401K or IRA) $
☐ Life Insurance $	☐ Life Insurance $	☐ Life Insurance $
☐ Other deduction: _____ $	☐ Other deduction: _____ $	☐ Other deduction: _____ $
Date of next paycheck (mm/dd/yyyy):		
/ /	/ /	/ /
How many hours does this person usually work each week?		
Regular hours / Overtime hours	Regular hours / Overtime hours	Regular hours / Overtime hours
▶ If this job pays hourly, what is the hourly rate?		
Regular rate $ /hr / Overtime rate $ /hr	Regular rate $ /hr / Overtime rate $ /hr	Regular rate $ /hr / Overtime rate $ /hr
Do any of these jobs include tips, commissions or bonuses?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what type? Check all that apply.		
☐ Tips ☐ Commissions ☐ Bonuses	☐ Tips ☐ Commissions ☐ Bonuses	☐ Tips ☐ Commissions ☐ Bonuses
▶ **If yes,** what is the usual amount before deductions?		
$	$	$
How often? ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Quarterly ☐ Twice a month ☐ Yearly	**How often?** ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Quarterly ☐ Twice a month ☐ Yearly	**How often?** ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Quarterly ☐ Twice a month ☐ Yearly

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

G

Is anyone in your household self-employed?

Self-employed means the 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.

☐ No ☐ Yes **If yes,** complete the following.

If you need to tell us about more than 3 self-employed jobs, make a copy of this page before you fill it out. Attach the copy to your application.

We may ask you to send your most recent personal and business income tax returns, including all pages and attachments.

Self-employed job #1	Self-employed job #2	Self-employed job #3
Name of self-employed person	Name of self-employed person	Name of self-employed person
Business name (if any)	Business name (if any)	Business name (if any)
What type of business is it?	What type of business is it?	What type of business is it?
What is the estimated monthly income this year?		
$	$	$
What are the estimated monthly expenses this year?		
$	$	$
Have the monthly income or expenses changed since you filed taxes last year?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** why have they changed?		

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G

Does anyone in your household have income from sources other than work?

☐ No ☐ Yes **If yes,** complete the following.

You are not required to tell us about some kinds of income such as SSI, veterans' payments, child support, tribal income obtained from natural resources, designated Indian trust land, or sales of items with cultural significance.

If you need to tell us about multiple household members receiving any of the income items below, make copies of this page before you fill it out. Attach the copy to your application.

Type or source of income	Name of person who receives this income	Amount	How often	Claim number, if any
Social Security benefits ☐ No ☐ Yes		$		
Trust or annuity payments ☐ No ☐ Yes		$		
Retirement or pension source: _____ ☐ No ☐ Yes		$		
Workers' compensation ☐ No ☐ Yes		$		
Unemployment ☐ No ☐ Yes		$		
Tribal payments ☐ No ☐ Yes		$		
Oil royalties or mineral rights ☐ No ☐ Yes		$		
Contract sale ☐ No ☐ Yes		$		
Rental income ☐ No ☐ Yes		$		
Spousal support from an agreement or agreement change dated December 31, 2018, or earlier ☐ No ☐ Yes		$		
Single payout lottery or gambling winnings of $80,000 or more after January 1, 2018. ☐ No ☐ Yes **If yes,** when: / /		$		
Other income source: _____ ☐ No ☐ Yes		$		

H Health insurance

Tell us about health insurance policies your household has now or had in the last 3 months. For example, if you are applying in August, include policies from May, June, July and August. Also include policies for household members under age 19. If you do not know an answer, write "unknown."

If you need to tell us about more than 3 policies, make a copy of this page before you fill it out. Attach the copy to your application.

Tell us about health insurance policies household members have now or had in the last 3 months:

Policy #1	Policy #2	Policy #3
Policyholder's name	Policyholder's name	Policyholder's name
Policyholder's SSN __ __ __ - __ __ - __ __ __ __	Policyholder's SSN __ __ __ - __ __ - __ __ __ __	Policyholder's SSN __ __ __ - __ __ - __ __ __ __
Names of household members on this policy:	Names of household members on this policy:	Names of household members on this policy:
Insurance company name	Insurance company name	Insurance company name
Insurance company address	Insurance company address	Insurance company address
Policy number	Policy number	Policy number
Group number	Group number	Group number
Start date / / End date / /	Start date / / End date / /	Start date / / End date / /
If ended, why? (left job, too expensive, etc.)	If ended, why? (left job, too expensive, etc.)	If ended, why? (left job, too expensive, etc.)
Type of coverage	Type of coverage	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: _____

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I Health coverage from jobs

Answer the questions on this page and the next page only if **both** of these statements are true for your household:

1. Someone in your household can get health coverage from a job.
   And
2. Your **gross** household income before taxes and deductions is **more** than the levels on the *Helpful Hints* flyer that came with this application.

Attach a copy of **pages 23-24** for each job that offers coverage. Tell us about the **job** that offers coverage.

Employee

Employee first and last name	Employee Social Security Number (SSN) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Employer

Employer name	Employer Identification Number (EIN)	
Employer address		
City	State	ZIP Code
Employer phone number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___		

Who can we contact about employee health coverage at this job?

First and last name	Phone number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___
	Email address

Do you qualify now or will you qualify in the next 3 months for coverage offered by this employer?

☐ No **If no,** stop here and go to Section J on **page 25**.
☐ Yes **If yes**, please answer the questions below.

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

Date you can enroll (mm/dd/yyyy): / /

List the names of any household members who qualify for coverage from this job:

First and last name	First and last name
First and last name	First and last name
First and last name	First and last name

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

I

Tell us about the health plan offered by the employer.

Does the employer offer a health plan that meets the minimum value standard? *See definition at right.*

☐ No ☐ Yes

Tell us about the premium (cost) for the **lowest** cost **individual** plan that is offered **only** to the employee and meets the **minimum value standard** (see box at right). Don't include family plans.

If the employer offers wellness programs, use the premium amount the employee would pay after the maximum discount for any **quit smoking** programs. Do not include discounts for other wellness programs.

Minimum value standard (MVS)

A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services.

Most job-based plans meet the minimum value standard.

How much would the employee pay for the employer-offered, lowest cost, individual, MVS plan?

Premium amount	How often?		
$	☐ Weekly	☐ Every 2 weeks	☐ Twice a month
	☐ Monthly	☐ Quarterly	☐ Yearly

What change will the employer make for the new plan 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 that is available **only** to the employee and meets the minimum value standard. Premium should reflect the discount for wellness programs. See above question.

☐ I don't know

▶ How much will the employee have to pay in premiums for this plan?

Premium amount	How often?			Date of change (mm/dd/yyyy):
$	☐ Weekly	☐ Every 2 weeks	☐ Twice a month	/ /
	☐ Monthly	☐ Quarterly	☐ Yearly	

J Parent living outside of the home

Does anyone on this application have a child under the age of 19 whose other parent lives outside the home?

☐ No ☐ Yes

▶ **If yes,** that person will be asked to cooperate with the agency that collects medical support from an absent parent.

If that person thinks that cooperating to collect medical support will bring harm to them or their children, they can tell KanCare and may not have to cooperate.

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K American Indian or Alaska Native

Complete this page if you or family members are American Indian or Alaska Native. If you need to tell us about more than 3 people, make copies of this page before you fill it out. Attach the copies to your application.

Tell us about your American Indian or Alaska Native family members.

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Service, 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.

AI or AN Person 1	AI or AN Person 2	AI or AN Person 3
First and last name	First and last name	First and last name
Is this person a member of a federally recognized tribe?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what is the name of the tribe?		
Name of the tribe	Name of the tribe	Name of the tribe
Has this person ever gotten a service or a referral from the Indian Health Service, a tribal health program or an urban Indian health program?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If no,** does this person qualify for services or a referral from the Indian Health Service, a tribal health program or an urban Indian health program?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ 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, or leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) • Money from selling things that have cultural significance		
Amount of income $	Amount of income $	Amount of income $
How often?	How often?	How often?

L Choose a health plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please read the *Extra Services Highlights* flyer that came with this application. Then choose your plan. We will only use the health plan information if you qualify for coverage.

If **you** choose, we will enroll you in that plan if you qualify 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. To learn more about the plans, visit www.KanCare.ks.gov.

If you do **not** qualify for a KanCare plan, you will get information about other coverage and services separately.

Choose a health plan for each person. The plans can be the same or different.

If you have more than 6 people in your household, make a copy of this page before you fill it out. Attach the copy to your application.

Person 1	Person 2	Person 3
First and last name	First and last name	First and last name
☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas
☐ sunflower health plan	☐ sunflower health plan	☐ sunflower health plan
☐ UnitedHealthcare	☐ UnitedHealthcare	☐ UnitedHealthcare

Person 4	Person 5	Person 6
First and last name	First and last name	First and last name
☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas	☐ aetna Aetna Better Health of Kansas
☐ sunflower health plan	☐ sunflower health plan	☐ sunflower health plan
☐ UnitedHealthcare	☐ UnitedHealthcare	☐ UnitedHealthcare

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M If you have someone to help you with your case

If you have someone to help you with your case, that person can also be your **Medical Representative** or **Facilitator**. You will choose a date below for a Facilitator's help to end.

If you choose to have a **Medical Representative**, that person can:

- Help you complete the application
- Make decisions about your case
- Get copies of letters about your case during **and** after the application process
- Talk with KanCare about your case
- Use your medical card to request services for you
- Request a fair hearing about your case and represent you at the hearing
- **Not** be someone who is trying to collect a medical debt against you or be an employee of a nursing facility

If you choose to have a **Facilitator**, that person cannot help you make decisions about your case. You will be in charge of your case. Your Facilitator can:

- Help you complete the application
- Get copies of letters and information during the application process, or for up to one year

I choose this person to help as my: ☐ **Medical Representative** ☐ **Facilitator**

First and last name	Organization name (if any)

Address	City	State	ZIP Code

Phone number	Email address

This person is my (parent, friend, lawyer, etc.):

▶ If you choose a Facilitator, how long do you want this person to help with your case? Check one.

☐ During the application process or for 6 months, whichever is later

☐ Until 1 year after the date I sign this application on **page 30**

☐ Until (mm/dd/yyyy) _____/_____ /_____
(cannot be longer than 1 year unless Facilitator is your parent, child or attorney)

Guardian, Conservator, Financial Power of Attorney or Social Security Payee

▶ If you are a guardian, conservator, financial power of attorney or Social Security payee completing this application for someone, tell us your information below. You must also send proof 📎.

First and last name

Address	City	State	ZIP Code

Phone number	Email address

N Read and sign

Before you send your application, you must sign and date it on **page 30**.

Please read the information below. Then **sign and date** in the spaces provided.

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.

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N Read and sign *(continued)*

- 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.

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

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

N Read and sign *(continued)*

By signing this application, I state that:

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

Primary applicant must sign here — Date

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

If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here — Date

If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here — Date

Medical representative may sign here (if any) — Date

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List of proof

This is a list of proof we may need. You do not have to send proof now. We will try to obtain this proof through other means. We may contact you later for this proof if we cannot obtain it on our own.

Proof of income

- **If you are self-employed**
  We may ask you to send copies of all pages and attachments of your most recent personal and business income tax returns.
- **If you have a job**
  We may ask you to send copies of your pay stubs for the last 30 days or a statement from your employer with your gross income before deductions.
- **If you have other income**
  We may ask you to send a copy of the check or benefit letter with the income amount and how often you get the payment.
- **If you want help with unpaid medical bills from the past 3 months**
  We may ask you to send copies of all pay stubs 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**
  We may ask you to send a copy of the front and back of your insurance card.

Did you remember to:

1. **Answer all questions on the application?**

2. **Tell us about all household members even if they don't need medical assistance?**

3. **Include any proof you want to send now?**

4. **Sign the application on page 30?**

5. **Finally, mail or fax your completed and signed application to:**
KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738

Fax: 1-800-498-1255

If they are not registered to vote where they live now, would anyone in your household like to register to vote today?

☐ Yes ☐ No

- Your answer will not affect the assistance you may receive from this agency.
- If you checked **yes**, we will send you a voter registration form. If you want help filling it out, we can help. Or you can fill out the form in private.
- If you believe that someone has interfered with:
  - your right to register or not register to vote,
  - your right to privacy in deciding or applying to register to vote, or
  - your right to choose your own political party or other political preference,

then you can file a complaint by mail or phone:

By mail
Kansas Secretary of State
Memorial Hall
120 SW 10th Avenue
Topeka, KS 66612-1594

By phone
1-800-262-8683

KanCare

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

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Elderly and Persons with Disabilities
Medical Assistance Application

Apply faster online! Go to ApplyforKanCare.ks.gov.

This application is for elderly persons, persons with a disability, and families that include a child with a disability. If you are pregnant or your family does not include a child with a disability, use the ***Families with Children*** *Medical Assistance Application*.

Make sure you:

1. **Answer** all questions on the application
2. **Sign** the application on page 30
3. **Include** any proof you want to send. You do not have to send any proof now. See page 31 for a list of proof we may need if we cannot obtain it on our own.
4. **Mail** your completed and signed application to:

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

   Or Fax to: 1-844-264-6285

Contents

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

By law, we must keep your information private. We will use your application information only to see if you qualify for medical assistance.

We have free interpreters if you need help in other languages.

العربية / ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافرلك بالمجان. اتصل برقم 1-800-792-4884 (رقم هاتف الصم والبكم: 1-800-792-4292).

မွန်မာ / BURMESE

သတိပြုရန် - အ ယ်၍ သင်သည် မြန်မာစ ား ို ပြောပါ ၊ ဘာသာစ ား အ ူအညီ၊ အခမဲ့၊ သင့်အတွ ် စီစဉ်ဆောင်ရွ ်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-792-4884** (TTY: **1-800-792-4292**) သို့ ခေါ်ဆိုပါ။

中文 / CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-792-4884 (**TTY: **1-800-792-4292)**。

فارسی / FARSI

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-792-4884 (TTY: 1-800-792-4292) تماس بگیرید.

FRANÇAIS / FRENCH

Attention: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-792-4884** (ATS : **1-800-792-4292).**

DEUTSCHE / GERMAN

Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-792-4884** (TTY: **1-800-792-4292**).

HMOOB / HMONG

Lus Ceev: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-792-4884** (TTY: **1-800-792-4292**).

日本語 / JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-792-4884** (TTY: **1-800-792-4292**) まで、お電話にてご連絡ください。

한국어 / KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-792-4884** (TTY: **1-800-792-4292**) 번으로 전화해 주십시오.

한국어 / LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽ້ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-792-4884** (TTY: **1-800-792-4292**).

РУССКИЙ / RUSSIAN

Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-792-4884** (телетайп: **1-800-792-4292**).

ESPAÑOL / SPANISH

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-792-4884** (TTY: **1-800-792-4292**).

SWAHILI

Kumbuka: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu **1-800-792-4884** (TTY: **1-800-792-4292**).

TAGALOG

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-792-4884** (TTY: **1-800-792-4292**).

TIẾNG VIỆT / VIETNAMESE

Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-792-4884** (TTY: **1-800-792-4292**).

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For this application, your household includes these people:

- Yourself (the primary applicant)
- Your legally married spouse, whether they live with you or not
- Your partner who lives with you, **only** if you have children together
- Parents of a minor child

Include **all** of the people in your household, even if you are not applying for them. Also include household members temporarily living out of the home.

Anyone who is **not** in this list will need to fill out their own application to apply for medical assistance.

The paper clip means we may ask for proof later. Or you can send it now. See the list on page 31.

A Tell us about the primary applicant

The primary applicant is the person who needs medical assistance.
If the person who needs medical assistance is a child, then the primary applicant is the child's parent or the head of household. Where you see "Yourself" and "You" that also means the primary applicant.

Primary applicant: Yourself *(or the parent or head of household if the person applying is a child)*

Your name

First name	Middle name	Last name

Other names used (such as maiden name)

Your contact information

Home address		**Mailing** address (if different from **Home** address)	
City	State	City	State
County	ZIP Code	County	ZIP Code

☐ Check here if you don't have a home address. You still need to give a mailing address.

Home phone	Work phone
___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

▶ May we contact you by:

☐ Email Email address:

☐ Text Cell phone number: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

What language do you **speak** at home?	What language do you **read and write** at home?

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

B Tell us about yourself and the people in your household

- Start with yourself (the primary applicant, or the parent or head of household if the person applying is a child).
- There is room on this application for 3 people. If more than 3 people are in your household, make copies of **pages 4–12** before you fill them out. Use the copies to complete persons 4, 5, 6 and so on. Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
What is each person's relationship to you?		
Person 1 is my: ***Self***	Person 2 is my:	Person 3 is my:
Gender		
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)		
/ /	/ /	/ /
Marital status		
☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)	☐ Married (includes common law, separated) ☐ Not married (includes divorced, widowed)
Does this person live at the same address as Person 1?		
Leave blank	☐ No ☐ Yes	☐ No ☐ Yes
	▶ **If no**, list address:	▶ **If no**, list address:

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B

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Was this person in Kansas foster care on their 18th birthday?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Medical assistance may help pay for medical and hospital bills, doctor visits, medicine, Medicare premiums, in-home assistance, and nursing home and institutional care.

Is this person applying for medical assistance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** what types of medical assistance does each person need? Read the descriptions below. Check the boxes for all programs each person needs. KanCare will tell you if you qualify.		
☐ Standard Medicaid (with medical card) ☐ HCBS (includes assisted living) ☐ Nursing home or other facility ☐ PACE ☐ Medicare costs **only** (no other KanCare assistance) ☐ Medically Needy (Spenddown) ☐ Working Healthy	☐ Standard Medicaid (with medical card) ☐ HCBS (includes assisted living) ☐ Nursing home or other facility ☐ PACE ☐ Medicare costs **only** (no other KanCare assistance) ☐ Medically Needy (Spenddown) ☐ Working Healthy	☐ Standard Medicaid (with medical card) ☐ HCBS (includes assisted living) ☐ Nursing home or other facility ☐ PACE ☐ Medicare costs **only** (no other KanCare assistance) ☐ Medically Needy (Spenddown) ☐ Working Healthy

Types of medical assistance

Home and Community Based Services (HCBS) is for children with disabilities and elderly or disabled adults who have a medical need for services in the community so they can live at home or in assisted living.

Nursing home or other facility is for children with disabilities and elderly or disabled adults who live in a nursing home, medical or mental health institution, or similar facility for a long-term stay.

Program of All-Inclusive Care for the Elderly (PACE) is for adults who live in certain counties and are age 65 or older **or** are disabled and age 55 or older. Persons who qualify get long-term care coverage through a managed care network so they can stay in the community.

Medicare Savings Program (Medicare costs) is for people who have Medicare. This program pays the Medicare Part B premiums. It may also pay Medicare co-payments and deductibles.

Medically Needy (Spenddown) is for persons in the community who have a disability or are age 65 or older. It uses medical expenses to "spend down" (lower) your income so you qualify for Medicaid.

Working Healthy is for people with disabilities who qualify. It helps them get or keep Medicaid coverage while working.

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

B

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. We use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are **not** applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. If you don't give your SSN, you can still apply.		
What is this person's Social Security Number?		
Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __	Social Security Number __ __ __-__ __-__ __ __ __
Is this person a U.S. citizen or U.S. national? **Must** answer if applying for medical assistance.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us this person's alien number and certificate number.		
Alien number (optional)	Alien number (optional)	Alien number (optional)
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
If this person is **not** a U.S. citizen or U.S. national, do they have eligible immigration status?		
☐ Yes	☐ Yes	☐ Yes
▶ **If yes,** tell us more about this person's immigration status.		
Document type	Document type	Document type
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
Card number or passport number	Card number or passport number	Card number or passport number
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
Other (category code or country where issued)	Other (category code or country where issued)	Other (category code or country where issued)

B

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Has this person lived in the U.S. since 1996?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
What is this person's **race**? Check all that apply. *This question is optional. You do not have to answer.*		
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Other Pacific Islander ☐ Vietnamese ☐ White ☐ Other
What is this person's **ethnicity**? If Hispanic or Latino ethnicity, check all that apply. *This question is optional. You do not have to answer.*		
☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other	☐ Cuban ☐ Mexican ☐ Mexican American Chicano/a ☐ Puerto Rican ☐ Other

B

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Which of these best describes where the person lives now?		
☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted living ☐ Nursing facility or other institution ☐ Hospital ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted living ☐ Nursing facility or other institution ☐ Hospital ☐ Other	☐ Own home ☐ Renting ☐ Live with someone else ☐ Assisted living ☐ Nursing facility or other institution ☐ Hospital ☐ Other
Is this person living outside of the home?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** why is this person living outside of the home?		
Reason	Reason	Reason
Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /
▶ If in a hospital, nursing facility or other institution, what is the name of the facility?		
Name of facility	Name of facility	Name of facility
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /
Does this person pay out of pocket for medical expenses not covered by Medicare, Medicaid or private insurance?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** tell us about the expenses.		
How much? $	How much? $	How much? $
How often?	How often?	How often?
Describe the expense:	Describe the expense:	Describe the expense:

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Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Has this person ever been in a hospital or nursing facility for more than 30 days in a row?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when? (mm/dd/yyyy)		
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /
Has this person served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
VA file number	VA file number	VA file number
If this person has **not** served in the military, has this person ever been married to someone who has served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** is this person a widow or widower of someone who served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** has this person remained unmarried after the death of the spouse who served in the military?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is this person pregnant?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how many babies are expected?		
▶ **If yes,** what is the expected due date? Estimate if unknown. (mm/dd/yyyy) *This question is optional. You do not have to answer.*		
/ /	/ /	/ /

C Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July.

Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for you and all others who are applying (Person 2, Person 3, etc.).

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Does this person need help paying medical bills from the last 3 months, including Medicare premiums?		
☐ 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
Has this person lived in a state other than Kansas in the last 3 months?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

Tell us about changes in your household

Has your household **size** changed in the last 3 months because someone moved in or out?

☐ No ☐ Yes **If yes,** tell us about the changes to your **household**:

Has your household **income** changed in the last 3 months?

☐ No ☐ Yes **If yes,** tell us about the changes to your **income**:

Have your household **resources** changed in the last 3 months?

☐ No ☐ Yes **If yes,** tell us about the changes to your **resources**:

D Federal income tax information

Tell us how you and your household plan to file your taxes.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Based on your current situation, does this person plan to file a federal income tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** will this person file jointly with a spouse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, name of spouse	**If yes,** name of spouse	**If yes,** name of spouse
▶ **If yes,** does this person have any dependents on their tax return?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, list names of dependents	**If yes,** list names of dependents	**If yes,** list names of dependents
Is this person claimed as a dependent on the tax return of someone who is **not** a household member?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, who **claims** Person 1 as a dependent on their tax return?	**If yes,** who **claims** Person 2 as a dependent on their tax return?	**If yes,** who **claims** Person 3 as a dependent on their tax return?
How is Person 1 related to the person who **claims** them? *For example, Person 1 is the **child** of the person who claims them.*	How is Person 2 related to the person who **claims** them? *For example, Person 2 is the **child** of the person who claims them.*	How is Person 3 related to the person who **claims** them? *For example, Person 3 is the **child** of the person who claims them.*

E Tell us about deductions

We need to know about deductions on the federal income tax returns for members of your **household**, such as alimony, student loan interest, etc. This could help lower your cost for medical assistance. Do not include deductions related to self-employment. If you have more than 3 deductions, make a copy of this page before you fill it out. Attach the copy to your application.

Deduction #1	Deduction #2	Deduction #3
Name of person with deduction	Name of person with deduction	Name of person with deduction
Type of deduction	Type of deduction	Type of deduction
Amount $	Amount $	Amount $
How often?	How often?	How often?

F Tell us if anyone is disabled

We need to know if anyone in your household has a disability. We will not share personal health information given here. We will use it only to decide disability status.

Person 1 *(continued)*	Person 2 *(continued)*	Person 3 *(continued)*
First and last name	First and last name	First and last name
Does this person have a disability that will last at least 12 months or result in death?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Has this person ever applied for Social Security benefits? **If yes,** answer the questions below.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ What was the outcome of the Social Security application?		
☐ Approved ☐ Denied ☐ Pending ☐ In appeal	☐ Approved ☐ Denied ☐ Pending ☐ In appeal	☐ Approved ☐ Denied ☐ Pending ☐ In appeal
▶ If denied or in appeal, has the existing condition become worse?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ If denied or in appeal, does this person have a new disability or condition that Social Security did not look at?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, briefly describe the disability or condition.	**If yes,** briefly describe the disability or condition.	**If yes,** briefly describe the disability or condition.

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G Resources

We need to know about the resources of the **primary applicant** (or the parent or head of household if the person applying is a child) and their **spouse**, if they have one. If you need more room, attach extra pages. See the list of proof we need for each on **page 31**.

1. Does the primary applicant or their spouse have any of the resources listed below?

Check No or Yes. **If yes,** tell us about the resource.

If the primary applicant or spouse has more than one of any of the resources listed below, use "Other" at the end of the list to add them.

Type of resource	Name on resource	Amount or value	Where resource is held *(name of bank, credit union or company)*	Account number
Cash ☐ No ☐ Yes		$		
Checking account ☐ No ☐ Yes		$		
Savings account or certificate of deposit (CD) ☐ No ☐ Yes		$		
Retirement plan ☐ No ☐ Yes		$		
Nursing facility accounts ☐ No ☐ Yes		$		
Stocks and bonds ☐ No ☐ Yes		$		
Funeral or burial plans ☐ No ☐ Yes		$		
Burial plots ☐ No ☐ Yes		$		
Other: _____ ☐ No ☐ Yes		$		
Other: _____ ☐ No ☐ Yes		$		

G

2. Does the primary applicant or their spouse have any vehicles?

☐ No ☐ Yes **If yes,** complete the following.

Vehicle #1		**Vehicle #2**		**Vehicle #3**	
Year		Year		Year	
Make	Model	Make	Model	Make	Model
Owner		Owner		Owner	
Estimated value $	Amount owed $	Estimated value $	Amount owed $	Estimated value $	Amount owed $
How is this vehicle used? ☐ Personal ☐ Business ☐ Both		How is this vehicle used? ☐ Personal ☐ Business ☐ Both		How is this vehicle used? ☐ Personal ☐ Business ☐ Both	

3. Does the primary applicant or their spouse have life insurance?

☐ No ☐ Yes **If yes,** complete the following. You can send a copy of the life insurance policy.

Policy owner	Insurance company	Policy number	Face value	Cash value
			$	$
			$	$
			$	$

4. Does the primary applicant or their spouse own a home?

☐ No ☐ Yes **If yes,** complete the following.

Owners		Property address	
Date purchased (mm/dd/yyyy) / /	Value $	Amount owed $	
Who lives in the home?			
If the owner does not live there, explain why:		If the owner does not live there, does the owner plan to return home? ☐ No ☐ Yes	

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G

5. Does the primary applicant or their spouse own other real estate?

☐ No ☐ Yes **If yes,** complete the following.

Describe the type of property (building, lot, second home, etc.)		Is this property used as rental or income producing property? ☐ No ☐ Yes
Owners	Property address	
Date purchased (mm/dd/yyyy) / /	Value of property $	Amount owed $

6. Does the primary applicant or their spouse have a life estate or life interest in any property?

☐ No ☐ Yes **If yes,** complete the following.

Describe the type of property

Owners	Property address	
Date life estate was created (mm/dd/yyyy) / /	Value of property $	Amount owed $

7. Does the primary applicant or their spouse have a trust?

☐ No ☐ Yes **If yes,** you can send a copy of your trust.

8. Does the primary applicant or their spouse have an annuity or other similar investment, including those issued as part of a retirement package?

☐ No ☐ Yes **If yes,** complete the following. You can send a copy of the annuity or investment.

Owners	Value $
Company	

For long-term care assistance, the State of Kansas must be named as the beneficiary of any annuity you own that was bought on or after February 8, 2006. You will get more information about this. When you sign the application, you are agreeing to name the State of Kansas as beneficiary (inheritor) for your annuities.

9. Does anyone owe the primary applicant or their spouse money through a promissory note or other loans?

☐ No ☐ Yes **If yes,** complete the following.

Name of person who **owes you** money	How much $	What type of loan?

G

10. Does the primary applicant or their spouse have other resources (such as an R.V., trailer, boat, livestock, oil rights, machinery, etc.)?

☐ No ☐ Yes **If yes,** complete the following.

Resource	Owners	Value $
Resource	Owners	Value $

11. Has the primary applicant or their spouse taken a loan against any property in the last 5 years, including a second mortgage or reverse mortgage?

☐ No ☐ Yes

12. Has the primary applicant or their spouse ever waived rights to an inheritance or will?

☐ No ☐ Yes

13. Has the primary applicant or their spouse ever worked with an attorney or other professional for estate planning?

☐ No ☐ Yes **If yes,** complete the following.

Name of attorney	Date (mm/dd/yyyy) / /

14. Has the primary applicant or their spouse sold, traded, given away or changed ownership of any property in the last 5 years? This includes a house, money, cars or any other property.

Type of property	Value	Given or sold to	Date ownership changed	Reason it was given or sold
	$		/ /	
	$		/ /	
	$		/ /	

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H Jobs and other income

If you need to tell us about more than 3 jobs, make a copy of this page before you fill it out. Attach the copy to your application.

Does the primary applicant or their spouse have a job?

☐ No ☐ Yes **If yes,** tell us about **all** jobs the primary applicant and spouse have.

Job #1	Job #2	Job #3
Worker's name	Worker's name	Worker's name
Company name	Company name	Company name
Company address	Company address	Company address
Company phone	Company phone	Company phone
Start date (mm/dd/yyyy) / /	Start date (mm/dd/yyyy) / /	Start date (mm/dd/yyyy) / /
Income before any taxes or deductions are taken out:		
This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year	This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year	This person makes $ _____ every: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ 2 weeks ☐ Year
▶ What deductions are taken out of the gross pay before taxes? Check the box and tell us the amount:		
☐ Health Insurance (includes dental, vision, and accident) $	☐ Health Insurance (includes dental, vision, and accident) $	☐ Health Insurance (includes dental, vision, and accident) $
☐ Health Savings Accounts (HSAs) $	☐ Health Savings Accounts (HSAs) $	☐ Health Savings Accounts (HSAs) $
☐ Flexible Spending Accounts (FSAs) $	☐ Flexible Spending Accounts (FSAs) $	☐ Flexible Spending Accounts (FSAs) $
☐ Retirement Accounts (such as 401K or IRA) $	☐ Retirement Accounts (such as 401K or IRA) $	☐ Retirement Accounts (such as 401K or IRA) $
☐ Life Insurance $	☐ Life Insurance $	☐ Life Insurance $
☐ Other deduction: _____ $	☐ Other deduction: _____ $	☐ Other deduction: _____ $

H

Job #1 *(continued)*		Job #2 *(continued)*		Job #3 *(continued)*	
Worker's name		Worker's name		Worker's name	
Date of next paycheck (mm/dd/yyyy):					
/ /		/ /		/ /	
How many hours does this person usually work each week?					
Regular hours	Overtime hours	Regular hours	Overtime hours	Regular hours	Overtime hours
▶ If this job pays hourly, what is the hourly rate?					
Regular rate $ /hr	Overtime rate $ /hr	Regular rate $ /hr	Overtime rate $ /hr	Regular rate $ /hr	Overtime rate $ /hr
Do any of these jobs include tips, commissions or bonuses?					
☐ No ☐ Yes		☐ No ☐ Yes		☐ No ☐ Yes	
▶ **If yes,** what type?					
☐ Tips ☐ Commissions ☐ Bonuses		☐ Tips ☐ Commissions ☐ Bonuses		☐ Tips ☐ Commissions ☐ Bonuses	
▶ **If yes,** what is the usual amount **before** deductions?					
$		$		$	
How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month	☐ Monthly ☐ Quarterly ☐ Yearly	**How often?** ☐ Weekly ☐ Every 2 weeks ☐ Twice a month	☐ Monthly ☐ Quarterly ☐ Yearly	**How often?** ☐ Weekly ☐ Every 2 weeks ☐ Twice a month	☐ Monthly ☐ Quarterly ☐ Yearly

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H Is the primary applicant or spouse self-employed?

Self-employed means the 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.

☐ No ☐ Yes **If yes,** complete the following.

If you need to tell us about more than 3 self-employed jobs, make a copy of this page before you fill it out. Attach the copy to your application.

You can send your most recent personal and business income tax returns, including all pages and attachments.

Self-employed job #1	Self-employed job #2	Self-employed job #3
Name of self-employed person	Name of self-employed person	Name of self-employed person
Business name (if any)	Business name (if any)	Business name (if any)
What type of business is it?	What type of business is it?	What type of business is it?
When did the business start? / /	When did the business start? / /	When did the business start? / /
What is the estimated monthly income this year?		
$	$	$
What are the estimated monthly expenses this year?		
$	$	$
Have the monthly income or expenses changed since filing taxes last year?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** how have they changed?		
Were taxes filed on this income last year?		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

H

Does the primary applicant or their spouse have a disability and are they working?

☐ No ☐ Yes **If yes,** complete the following.

If you are or your spouse is a person with a disability who is working, list any expenses related to the disability that allow the person to work. This includes specialized transportation to and from work, attendant care at work, attendant care to get ready for work, service animals, medications and specialized equipment or tools.

Person 1: Yourself	Your spouse
Does this person have income from working?	
☐ No ☐ Yes	☐ No ☐ Yes
▶ **If yes,** list any expenses related to the disability that allow the person to work.	
Type of expense	Type of expense
Monthly amount $	Monthly amount $
Type of expense	Type of expense
Monthly amount $	Monthly amount $
Type of expense	Type of expense
Monthly amount $	Monthly amount $

H

Does the primary applicant or their spouse have income from sources other than work?

☐ No ☐ Yes **If yes,** complete the following.

Type or source of income	Name of person who receives this income	Amount	How often?	Claim number, if any
Social Security benefits ☐ No ☐ Yes		$		
Supplemental Security Income (SSI) ☐ No ☐ Yes		$		
Veterans' Benefits ☐ No ☐ Yes		$		
Railroad Retirement ☐ No ☐ Yes		$		
Trust payments ☐ No ☐ Yes		$		
Annuity payments ☐ No ☐ Yes		$		
Other retirement or pension source: _____ ☐ No ☐ Yes		$		
Workers' compensation ☐ No ☐ Yes		$		
Unemployment ☐ No ☐ Yes		$		
Tribal payments ☐ No ☐ Yes		$		
Oil royalties or mineral rights ☐ No ☐ Yes		$		
Contract sale ☐ No ☐ Yes		$		
Rental income ☐ No ☐ Yes		$		
Child support ☐ No ☐ Yes		$		
Spousal support ☐ No ☐ Yes		$		
Other income source 1 _____ ☐ No ☐ Yes		$		
Other income source 2 _____ ☐ No ☐ Yes		$		

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

I Medicare coverage

We need to know about all household members who have Medicare.
If you need to tell us about more than 3 people, make a copy of this page before you fill it out.
Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First and last name	First and last name	First and last name
Does this person have Medicare? **If yes,** answer the questions below.		
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medicare claim number	Medicare claim number	Medicare claim number
Medicare Part A? ☐ No ☐ Yes	Medicare Part A? ☐ No ☐ Yes	Medicare Part A? ☐ No ☐ Yes
Part A effective date (mm/dd/yyyy) / /	Part A effective date (mm/dd/yyyy) / /	Part A effective date (mm/dd/yyyy) / /
Medicare Part B? ☐ No ☐ Yes	Medicare Part B? ☐ No ☐ Yes	Medicare Part B? ☐ No ☐ Yes
Part B effective date / /	Part B effective date / /	Part B effective date / /
Medicare Part C? ☐ No ☐ Yes (Medicare Advantage)	Medicare Part C? ☐ No ☐ Yes (Medicare Advantage)	Medicare Part C? ☐ No ☐ Yes (Medicare Advantage)
Part C effective date / /	Part C effective date / /	Part C effective date / /
Part C premium amount $	Part C premium amount $	Part C premium amount $
Part C plan name	Part C plan name	Part C plan name
Medicare Part D? ☐ No ☐ Yes	Medicare Part D? ☐ No ☐ Yes	Medicare Part D? ☐ No ☐ Yes
Part D effective date / /	Part D effective date / /	Part D effective date / /
Part D premium amount $	Part D premium amount $	Part D premium amount $
Part D plan name	Part D plan name	Part D plan name

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J Other health insurance

Tell us about health insurance policies your household has now or had in the last 3 months.
For example, if you are applying in August, include policies from May, June, July and August.
Do **not** include information about Medicaid or Medicare.

If you need to tell us about more than 3 policies, make copies of pages 23–24 before you fill them out. Attach the copies to your application.

You can send a copy of a bill showing how much you pay for the health insurance.

Tell us about health insurance policies household members have now or had in the last 3 months, other than Medicare.

Policy #1		Policy #2		Policy #3	
Policyholder's name		Policyholder's name		Policyholder's name	
Policyholder's SSN __ __ __–__ __–__ __ __ __		Policyholder's SSN __ __ __–__ __–__ __ __ __		Policyholder's SSN __ __ __–__ __–__ __ __ __	
Names of household members on this policy:		Names of household members on this policy:		Names of household members on this policy:	
Insurance company name		Insurance company name		Insurance company name	
Insurance company address		Insurance company address		Insurance company address	
Policy number		Policy number		Policy number	
Group number		Group number		Group number	
Start date / /	End date / /	Start date / /	End date / /	Start date / /	End date / /

J

Policy #1 *(continued)*		Policy #2 *(continued)*		Policy #3 *(continued)*	
Type of coverage	Monthly premium	Type of coverage	Monthly premium	Type of coverage	Monthly premium
☐ Catastrophic only	$	☐ Catastrophic only	$	☐ Catastrophic only	$
☐ Dental	$	☐ Dental	$	☐ Dental	$
☐ Doctor	$	☐ Doctor	$	☐ Doctor	$
☐ Hospital	$	☐ Hospital	$	☐ Hospital	$
☐ Long-term care	$	☐ Long-term care	$	☐ Long-term care	$
☐ Medicare supplement	$	☐ Medicare supplement	$	☐ Medicare supplement	$
☐ Prescription	$	☐ Prescription	$	☐ Prescription	$
☐ Vision	$	☐ Vision	$	☐ Vision	$
☐ Other: _____	$	☐ Other: _____	$	☐ Other: _____	$

K Home and Community Based Services and institutional care

Complete this section only if **both** of these are true:

1. You are applying for Home and Community Based Services (HCBS) or institutional care.
   And
2. **One or more** of these is true:
   - » You have a spouse
   - » You have a dependent family member who lives with your spouse
   - » You have a dependent under age 18 who does not live with your spouse

If your household includes a spouse or dependent child not listed in Part C and you are applying for HCBS or institutional care, you must add that person to Part C.

Does anyone on this application live in a nursing or assisted living facility, or receive those services at home?

☐ No ☐ Yes

▶ **If yes,** please tell us about dependents and housing expenses on the next page.

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K

Dependents

Does this person have minor children or other family members who are dependent on them?

☐ No ☐ Yes

▶ **If yes,** please complete the following:

Dependent's name	Relationship to you	Date of birth (mm/dd/yyyy)	Person's monthly income	If a child, who does the child live with?	If a child living with another parent, list that parent's monthly income
		/ /	$		$
		/ /	$		$
		/ /	$		$

Housing expenses

Does this person have a spouse living at home or in assisted living?

☐ No ☐ Yes

▶ **If yes,** list the spouse's housing expenses below:

Type	How often?	Amount
Rent or lot rent		$
Mortgage payment		$
Property taxes, if not included in mortgage		$
Home or renter's insurance, if not included in rent or mortgage		$
Other, including condominium or home owners association (HOA) fee		$

L Choose a health plan

Most people approved for Kansas medical assistance receive services through KanCare. There are 3 KanCare health plans to choose from. Please read the *Extra Services Highlights* flyer that came with this application. Then choose your plan. We will only use the health plan information if you qualify for coverage.

If **you** choose, we will enroll you in that plan if you qualify 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. To learn more about the plans, visit www.KanCare.ks.gov.

If you do **not** qualify for a KanCare plan, you will get information about coverage and services separately.

Choose a health plan for each person. The plans can be the same or different.

If you have more than 3 people in your household, make a copy of this page before you fill it out. Attach the copy to your application.

Person 1	Person 2	Person 3
First and last name	First and last name	First and last name
☐ aetna® Aetna Better Health® of Kansas	☐ aetna® Aetna Better Health® of Kansas	☐ aetna® Aetna Better Health® of Kansas
☐ sunflower health plan™	☐ sunflower health plan™	☐ sunflower health plan™
☐ UnitedHealthcare®	☐ UnitedHealthcare®	☐ UnitedHealthcare®

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M If you have someone to help you with your case

If you have someone to help you with your case, that person can also be your **Medical Representative** or **Facilitator**. You will choose a date below for a Facilitator's help to end.

If you choose to have a **Medical Representative**, that person can:

- Help you complete the application
- Make decisions about your case
- Get copies of letters about your case during **and** after the application process
- Talk with KanCare about your case
- Use your medical card to request services for you
- Request a fair hearing about your case and represent you at the hearing
- **Not** be someone who is trying to collect a medical debt against you or be an employee of a nursing facility

If you choose to have a **Facilitator**, that person cannot make decisions about your case. You will be in charge of your case. Your Facilitator can:

- Help you complete the application
- Get copies of letters and information during the application process, or for up to one year

I choose this person to help as my: ☐ **Medical Representative** ☐ **Facilitator**

First and last name	Organization name (if any)

Address	City	State	ZIP Code

Phone number	Email address

This person is my (child, friend, lawyer, etc.):

▶ If you choose a Facilitator, how long do you want this person to help with your case?

☐ During the application process or for 6 months, whichever is later

☐ Until 1 year after the date I sign this application on page 30

☐ Until (mm/dd/yyyy) _____/_____ /_____
(cannot be longer than 1 year unless Facilitator is your parent, child or attorney)

Guardian, Conservator, Financial Power of Attorney or Social Security Payee

▶ If you are a guardian, conservator, financial power of attorney or Social Security payee completing this application for someone, tell us your information below. You must also send proof.

First and last name

Address	City	State	ZIP Code

Phone number	Email address

N Read and sign

Before you send your application, you must sign and date it on **page 30**.
Please read the information below. Then **sign and date** in the spaces provided.

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.

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N Read and sign *(continued)*

- 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 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

For help completing this application,
call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

N Read and sign *(continued)*

By signing this application, I state that:

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

Primary applicant must sign here ▶ Date

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

If primary applicant is unable to sign, or signed with an "X," have a **first** witness sign here ▶ Date

If primary applicant is unable to sign, or signed with an "X," have a **second** witness sign here ▶ Date

Medical representative may sign here (if any) ▶ Date

List of proof

This is a list of proof we may need. You can send your proof with the application so we can process it faster, but you do not have to send any proof now. We will try to obtain this proof through other means. We may contact you later for this proof if we cannot obtain it on our own.

Proof of income

- **If you are self-employed**
  We may ask you to send copies of all pages and attachments of your most recent personal and business income tax returns.
- **If you have a job**
  We may ask you to send copies of your pay stubs for the last 30 days or a statement from your employer with your gross income before deductions.
- **If you have other income**
  We may ask you to send a copy of the check or benefit letter with the income amount and how often you get the payment.
- **If you want help with unpaid medical bills from the past 3 months**
  We may ask you to send copies of all pay stubs 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**
  We may ask you to send a copy of a bill showing how much you pay for the health insurance. We may also ask you to send a copy of the front and back of your insurance card.

Proof of resources

We may ask you to send proof of all resources you report on this application, including:

- **Checking account, savings account, stocks and bonds, or CDs**
  Copy of your most recent statement
- **Funeral or burial plan**
  Copy of the plan, including the bill of goods and services with proof that funeral arrangements are set up as irrevocable
- **Trust or annuity**
  Copy of the trust or annuity
- **Life insurance**
  Letter from the life insurance company verifying owner of policy, face value, cash value, and any loans against the policy

Did you remember to:

1. **Answer all questions on the application?**

2. **Tell us about all household members even if they don't need medical assistance?**

3. **Include any proof you want to send now?**

4. **Sign the application on page 30?**

5. **Finally, mail or fax your completed and signed application to:**
KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738
Fax: 1-844-264-6285

If they are not registered to vote where they live now, would anyone in your household like to register to vote today?

☐ Yes ☐ No

- Your answer will not affect the assistance you may receive from this agency.
- If you checked **yes**, we will send you a voter registration form. If you want help filling it out, we can help. Or you can fill out the form in private.
- If you believe that someone has interfered with:
  - your right to register or not register to vote,
  - your right to privacy in deciding or applying to register to vote, or
  - your right to choose your own political party or other political preference,

then you can file a complaint by mail or phone:

By mail
Kansas Secretary of State
Memorial Hall
120 SW 10th Avenue
Topeka, KS 66612-1594

By phone
1-800-262-8683

KanCare

For help completing this application, call us at **1-800-792-4884** (TTY 1-800-792-4292). The call is free.

KC1500 6/21

NVRA MOU – EXHIBIT C - Voter Registration Application & generic cover letter

Kansas
Department of Health and Environment
Division of Health Care Finance

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

As part of the State's responsibility to provide you an opportunity to register to vote, we have enclosed a voter registration application as required by the National Voter Registration Act.

If you need additional voter registration forms or help filling one out, please call KanCare at 1-800-792-4884.

If you choose to register to vote at this time, you may either mail the completed form to your county election office (those addresses are provided with the voter registration form) or mail it to KanCare, P.O. Box 3599, Topeka, KS, 66601, or drop it off at any of our offices. If you deliver your completed form to KanCare, we will send it to your county election office. If you need help filling out or mailing this form, you can call our offices, or you can call the Secretary of State at 1-833-765-2003 for assistance. If you need interpretation assistance, call us at 1-800-792-4884 (TTY: 1-800-792-4292).

Voting is a great way for eligible Kansans to make their voices heard in our democracy. Your decision to register or not register to vote will not affect your benefits or the amount of assistance the agency will provide you.

You should only register to vote if you are a U.S. citizen who lives in Kansas, you are at least 18 years old or will be 18 years of age before the next election, and you are not currently in prison, on probation, or on parole for a felony conviction. If you have questions about your eligibility to register to vote, call the Secretary of State at 1-800-262-VOTE (8683). You must re-register each time you change your name, address, or party affiliation for voting, so you should re-register to vote if you have moved since the last time you voted. Please note that you will be required to show photo identification at the polls.

You may also choose to register to vote online by going to https://www.kdor.ks.gov/apps/voterreg/default.aspx. To register online, you must have a valid Kansas driver's license or a state-issued identification card. If you do not have either of these documents, you may register to vote using the paper form provided in this mailing or you can download one at the following link if you have a printer: https://www.kssos.org/forms/elections/voterregistration.pdf.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Kansas Secretary of State's Elections Division by calling 1-800-262-VOTE (8683) or sending an email to election@ks.gov.

Kansas Voter Registration Instructions

For further information, contact the Office of the Secretary of State, 1-800-262-VOTE (8683) V/TTY. This form is available at www.sos.ks.gov.

You can use this application to:

- register to vote in Kansas
- change your name, address, or affiliation with a political party

To register to vote, you must:

- be a U.S. citizen and a resident of the state of Kansas.
- have reached the age of 18 years before the next election.
- have received final discharge from imprisonment, parole, or conditional release if convicted of a felony.
- have abandoned your former residence and/or name.

How to register to vote:

- Return your completed application to your county. Addresses are on the back of this application. Your county election officer will mail you a notice when your application has been processed.
- Voter registration closes 21 days before any election. In order to be eligible to vote in that election, your application must be postmarked on or before that date.
- If you decline to register to vote, that fact will remain confidential and will be used for voter registration purposes only. If you do register to vote, the office where you apply will be kept confidential and will be used for voter registration purposes only.
- If this form is incomplete, it may be rejected.

Identification number requirements

Enter your current Kansas driver's license number or nondriver's identification card number. If you do not have either one, enter the last four digits of your Social Security number. If you do not have any of these numbers, write "none" in the box. The number will be used for administrative purposes only and will not be disclosed to the public. *K.S.A. 25-2309*

Rev. 10/8/20 tc

Print in blue or black ink, fold on the center line, seal, and return.

Kansas Voter Registration Application

Warning: If you submit a false voter registration application, you may be convicted and sentenced to up to 17 months in prison.

Qualifications: If you mark "no" in response to either Question 1 or 2, do *not* complete this form.

1. Are you a citizen of the United States of America? ○ **Yes** ○ **No**

2. Will you be 18 years of age on or before Election Day? ○ **Yes** ○ **No**

Last Name (please print)	First Name	Middle	Jr. Sr. II III	○ Male ○ Female

Residential Address (include apt. or space number)	City	County	Zip

Mailing Address (if different than residential address)	City	Zip	Date Residence Established (MM/DD/YY)

Birth Date (MM/DD/YY)	Daytime Phone Number (if available)	Naturalization Number (if applicable)	Driver's License Number or Last 4 Social Security (see instructions)

Party Affiliation: Choose one of the following: ○ Democratic ○ Republican ○ Libertarian ○ Not affiliated with a party

Complete if previously registered (please print)	Previous Name	Previous Residential Address (Street, City, State, Zip, County)

Signature: I swear or affirm that I am a citizen of the United States and a Kansas resident, that I will be 18 years old before the next election, that if convicted of a felony, I have had my civil rights restored, that I have abandoned my former residence and/or other name, and that I have told the truth on this application.

Signature	Date (MM/DD/YY)

For office use only: Ward _____ Pct. _____ School Dist. _____ Member Dist. _____

Sen. _____ Rep. _____ CoComm _____ Section _____ Township _____ Range _____

Scott Schwab, Secretary of State
Memorial Hall, 1st Floor
120 S.W. 10th Avenue
Topeka, KS 66612-1594

OFFICIAL ELECTION MAIL
Authorized by the U.S. Postal Service ®

Post Office Will Not Deliver Without Postage

County Election Officer

_____ **County**

_____

_____**, KS** _____

Allen County 1 N. Washington Iola, KS 66749	**Coffey County** 110 S. 6th St Rm 202 Burlington, KS 66839	**Geary County** 200 E. 8th St Junction City, KS 66441	**Johnson County** 2101 E. Kansas City Rd Olathe, KS 66061	**Miami County** 201 S. Pearl Ste 102 Paola, KS 66071	**Pratt County** 300 S. Ninnescah / Box 885 Pratt, KS 67124	**Sherman County** 813 Broadway Rm 102 Goodland, KS 67735
Anderson County 100 E. 4th Garnett, KS 66032	**Comanche County** 201 S. New York / Box 776 Coldwater, KS 67029	**Gove County** P.O. Box 128 Gove, KS 67736	**Kearny County** 304 N. Main / Box 86 Lakin, KS 67860	**Mitchell County** 111 S. Hersey / Box 190 Beloit, KS 67420	**Rawlins County** 607 Main Atwood, KS 67730	**Smith County** 218 S. Grant Smith Center, KS 66967
Atchison County 423 N. 5th Atchison, KS 66002	**Cowley County** 321 E. 10th Ave. Winfield, KS 67156	**Graham County** 410 N. Pomeroy Hill City, KS 67642	**Kingman County** 130 N. Spruce Kingman, KS 67068	**Montgomery County** 217 E. Myrtle / Box 446 Independence, KS 67301	**Reno County** 125 W. 1st Ave. Hutchinson, KS 67501	**Stafford County** 209 N. Broadway St John, KS 67576
Barber County 120 E. Washington Medicine Lodge, KS 67104	**Crawford County** 111 E. Forest / Box 249 Girard, KS 66743-0249	**Grant County** 108 S. Glenn Ulysses, KS 67880	**Kiowa County** 211 E. Florida Greensburg, KS 67054	**Morris County** 501 W. Main Council Grove, KS 66846	**Republic County** 1815 M. Street Belleville, KS 66935	**Stanton County** 201 N. Main / Box 190 Johnson, KS 67855
Barton County 1400 Main Rm 202 Great Bend, KS 67530	**Decatur County** P.O. Box 28 Oberlin, KS 67749	**Gray County** P.O. Box 487 Cimarron, KS 67835	**Labette County** 501 Merchant / Box 387 Oswego, KS 67356	**Morton County** 1025 Morton / Box 1116 Elkhart, KS 67950	**Rice County** 101 W. Commercial Lyons, KS 67554	**Stevens County** 200 E. 6th Hugoton, KS 67951
Bourbon County 210 S. National Fort Scott, KS 66701	**Dickinson County** 109 E. First / Box 248 Abilene, KS 67410	**Greeley County** P.O. Box 277 Tribune, KS 67879	**Lane County** 144 S. Lane / Box 788 Dighton, KS 67839	**Nemaha County** 607 Nemaha / Box 186 Seneca, KS 66538	**Riley County** 110 Courthouse Plaza Manhattan, KS 66502	**Sumner County** 501 N. Washington Wellington, KS 67152
Brown County 601 Oregon St Hiawatha, KS 66434	**Doniphan County** P.O. Box 278 Troy, KS 66087	**Greenwood County** 311 N. Main Eureka, KS 67045	**Leavenworth County** 300 Walnut Leavenworth, KS 66048	**Neosho County** 100 S. Main / Box 138 Erie, KS 66733	**Rooks County** 115 N. Walnut Stockton, KS 67669	**Thomas County** 300 N. Court Ave Colby, KS 67701
Butler County 205 W. Central El Dorado, KS 67042	**Douglas County** 1100 Massachusetts St Lawrence, KS 66044	**Hamilton County** 219 N. Main / Box 1167 Syracuse, KS 67878	**Lincoln County** 216 E. Lincoln Ave Lincoln, KS 67455	**Ness County** 202 W. Sycamore Ness City, KS 67560	**Rush County** 715 Elm / Box 220 LaCrosse, KS 67548	**Trego County** 216 Main WaKeeney, KS 67672
Chase County Courthouse Sq / Box 529 Cottonwood Falls, KS 66845	**Edwards County** 312 Massachusetts St Kinsley, KS 67547	**Harper County** 201 N. Jennings Anthony, KS 67003	**Linn County** P.O. Box 350 Mound City, KS 66056	**Norton County** 105 S. Kansas / Box 70 Norton, KS 67654	**Russell County** 4th & Main / Box 113 Russell, KS 67665	**Wabaunsee County** 215 Kansas / Box 278 Alma, KS 66401
Chautauqua County 215 N. Chautauqua Sedan, KS 67361	**Elk County** 127 N. Pine / Box 606 Howard, KS 67349	**Harvey County** 8th & Main / Box 687 Newton, KS 67114	**Logan County** 710 W. 2nd Oakley, KS 67748	**Osage County** 717 Topeka Ave / Box 226 Lyndon, KS 66451-0226	**Saline County** 300 W. Ash / Box 5040 Salina, KS 67402	**Wallace County** P.O. Box 70 Sharon Springs, KS 67758
Cherokee County 110 W. Maple / Box 14 Columbus, KS 66725	**Ellis County** P.O. Box 720 Hays, KS 67601	**Haskell County** 300 Inman / Box 518 Sublette, KS 67877	**Lyon County** 430 Commercial Emporia, KS 66801	**Osborne County** 423 W. Main / Box 160 Osborne, KS 67473	**Scott County** 303 Court St Scott City, KS 67871	**Washington County** 214 C St Washington, KS 66968
Cheyenne County 212 E. Wash. / Box 985 St Francis, KS 67756	**Ellsworth County** 210 N. Kansas Ellsworth, KS 67439	**Hodgeman County** 500 Main Jetmore, KS 67854	**Marion County** 200 S. Third, Suite 104 Marion, KS 66861	**Ottawa County** 307 N. Concord Ste 130 Minneapolis, KS 67467	**Sedgwick County** 510 N. Main Wichita, KS 67203-3798	**Wichita County** 206 S. 4th Drawer 968 Leoti, KS 67861
Clark County 913 Highland St / Box 886 Ashland, KS 67831-0886	**Finney County** 311 N. 9th St., Box M Garden City, KS 67846	**Jackson County** 400 New York Holton, KS 66436	**Marshall County** 1201 Broadway Marysville, KS 66508	**Pawnee County** 715 Broadway Larned, KS 67550	**Seward County** 515 N. Washington Ste 100 Liberal, KS 67901	**Wilson County** 615 Madison Fredonia, KS 66736
Clay County 712 Fifth, Suite 102 Clay Center, KS 67432	**Ford County** 100 Gunsmoke Dodge City, KS 67801	**Jefferson County** P.O. Box 321 Oskaloosa, KS 66066	**McPherson County** 117 N. Maple McPherson, KS 67460	**Phillips County** 301 State St Phillipsburg, KS 67661	**Shawnee County** 3420 SW Van Buren Topeka, KS 66611	**Woodson County** 105 W. Rutledge Rm 103 Yates Center, KS 66783
Cloud County 811 Washington Concordia, KS 66901	**Franklin County** 315 S. Main Ottawa, KS 66067	**Jewell County** 307 N. Commercial Mankato, KS 66956	**Meade County** P.O. Box 278 Meade, KS 67864	**Pottawatomie County** 207 N. 1st / Box 187 Westmoreland, KS 66549	**Sheridan County** 925 9th St / Box 899 Hoxie, KS 67740	**Wyandotte County** 850 State Ave Kansas City, KS 66101

NVRA MOU – EXHIBIT D - KDHE Hip Pocket Guide

YOUR VOTER REGISTRATION RESPONSIBILITIES

Remember, it is Department policy and federal law that we must provide voter registration opportunities to all clients who apply for benefits, renew, recertify, or change address.

Registering and voting is a great way for our clients to make their voices heard.

To follow the law, we must:

1. **CONFIRM** that each client checks Yes or No to the voter registration question on the benefits form.
2. **GIVE** every client a voter registration application, unless that client checked “No” on the voter registration question (anyone who leaves that part blank gets an application).
3. **ASK** every client about voter registration in their interview and assure the client that any response is confidential and will not affect his or her benefit amount.
4. **PROVIDE** the same level of assistance with voter registration as you do for our benefits transactions, including making sure any voter registration applications are complete and signed.
5. **KNOW** the basic requirements to be eligible to vote in Kansas and how to fill out the voter registration application so you can provide assistance (see below).
6. **HAND OVER** any voter registration applications for mailing to the Secretary of State office within 5 days.
7. **MAINTAIN** the voter registration question with the client’s file and keep confidential any responses.

To be eligible to register and vote in Kansas, a person must:

- Be a U.S. citizen and a resident of the state of Kansas.
- Have reached the age of 18 years before the next election.
- If convicted of a felony, have received final discharge from
- imprisonment, parole, or conditional release.
- Have abandoned any former residence and/or name.

NVRA MOU – EXHIBIT E - Sample Change of Address Script

Change of Address – Voter Registration Script

“Thank you for providing us with your change of address. If you were registered to vote at your old address and want to vote at your new one, you will need to register to vote again.

We are required to provide Voter Registration material when needed. Because of this, you can anticipate receiving material in the mail in the next week or so with a voter registration application that you can complete if you so choose. If you complete it, you can either mail it back to your county election office or mail it back to us and we will submit it for you. Choosing to register or not, will not have any impact on your eligibility for services.”