




## **Kansas Department of Social and Rehabilitation Services** **Application for Benefits for the Elderly and Persons with Disabilities**

This is your application for the programs and services we offer. Answer all of the questions to the best of your ability. If English is not your preferred language, an interpreter will be provided at no cost to you.

### **Agency Use Only**

Date Received: \_\_\_\_\_  
Date Interviewed: \_\_\_\_\_  
\_\_\_\_\_ Initial \_\_\_\_\_ Review  
Valid Thru: \_\_\_\_\_  
Worker: \_\_\_\_\_  
Case Number(s): \_\_\_\_\_

This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form:

-  **Medical Assistance:** Medical assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay medical bills, doctor's visits and medicine. To apply for medical, fill out all of the sections where you see the medical bag.
  
-  **Food Assistance:** Food Assistance is electronic benefits you can use to buy food. If you need help buying food fill out all of the sections where you see the shopping cart. You may be eligible to receive food assistance within 7 days.
  
-  **Cash Assistance:** Cash assistance helps people with disabilities who are not getting Social Security (SSA) or Supplemental Security Income (SSI) benefits. To apply for cash, fill out all of the sections where you see the dollar sign.

### **Follow these steps to apply.**

- Complete this form or go on-line at [www.srskansas.org](http://www.srskansas.org) to apply. If you need help or have questions call 1-888-369-4777.
  - Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
  - Be sure to sign and date this form. Your application is not complete until it is signed.
  - If you can't complete the application right now, give your name, address, and signature on Page 1 and return the form. We need all of the information to see if you can get the help you request.
  - Return this form as soon as possible. If you are eligible, some benefits start from the date a signed application is received in our office.
  - Mail, fax or bring this form to your local SRS office. It may take 30 to 45 days before your application is processed.
  - If an interview is required, we will contact you.
  - A list of items we may need from you is on the last page of this form. Please tear off and keep for your records.
- Other services:** SRS also offers the services listed below. If you would like more information or to apply, please check the appropriate box.
- Child Support Enforcement** - To enforce child support orders and to help assure that children have access to financial support and health care.
  - Vocational Rehabilitation** - To help persons with disabilities become employed.
- Return this form to:**

## A. Help Us Decide If You Can Get Food/Medical Assistance Faster



If you have little or no money, we may be able to get you food assistance within 7 days. If you are pregnant, we may be able to get you a medical card within 10 days. Complete this section to help us decide if you can get benefits faster.

1. Is anyone in your household pregnant?

No  Yes If yes, list name and due date: \_\_\_\_\_

\_\_\_\_\_

2. Will your household's gross income for the month be less than \$150?

No  Yes

3. Does your household have less than \$100 in cash, checking, and savings?

No  Yes

4. Is anyone in your household a migrant or seasonal farm worker?

No  Yes

5. Enter your current rent/mortgage amount ..... \$ \_\_\_\_\_

6. Enter your current monthly utilities amount ..... +\$ \_\_\_\_\_

7. Shelter Expenses Total (add lines 5 & 6) ..... =\$ \_\_\_\_\_

8. Enter your household's gross income expected this month ..... \$ \_\_\_\_\_

9. Enter your household's total money in cash, checking & savings ..... +\$ \_\_\_\_\_

10. Expected Income & Resources Total (add lines 8 & 9) ..... =\$ \_\_\_\_\_

11. Are your household's shelter expenses (line 7) more than your household's expected gross income and resources (line 10)?

No  Yes

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#### Expedited FS?

No  Yes

#### Expedited Medical?

No  Yes

## B. Tell Us About Yourself and the People in Your Home



For which program(s) are you applying? Check all that apply.

 Medical Assistance   Food Assistance   Cash Assistance

**Tell us if you need any of the following medical programs:**

Working Healthy  Home and Community Based Services

Nursing Facility  Help with Medicare Costs

Provide the following information and sign this section of the application.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

First Name, Middle Initial, Last Name

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Are You:  Single  Married (Includes Common Law)  Divorced  Separated  Widowed

If widowed or divorced, list name(s) of your former spouse(s): \_\_\_\_\_

## B. Tell Us About Yourself and the People in Your Home (continued)



Benefits depend on who lives in your household and how they are related to you. Tell us about yourself first. Then tell us more about you and everyone in your household in the boxes below and on the next page. **Use the additional information sections on page 13 if there are more than 3 persons in your household.**

First Name, MI Last Name	Relation to You	Are you applying for this person?	Sex M/F	Birth Date	Social Security Number	Race/Ethnic Group (optional) <b>Use codes below</b> Race   Ethnicity		City and State of Birth/ Citizenship Status (List place of birth and check one box.)
	Self	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F					City and State of Birth _____  <input type="checkbox"/> Citizen <input type="checkbox"/> Noncitizen
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F					City and State of Birth _____  <input type="checkbox"/> Citizen <input type="checkbox"/> Noncitizen
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F					City and State of Birth _____  <input type="checkbox"/> Citizen <input type="checkbox"/> Noncitizen

**Race/Ethnicity Codes:** The following codes are for federal reporting purposes and will not affect your benefits.

**Race (choose as many as apply):** A = American Indian/Alaskan Native    B = Black/African American  
P = Native Hawaiian/Pacific Islander    S = Asian    W = White

**Ethnicity (choose only one):** H = Hispanic or Latino    N = Not Hispanic/Latino

- Which of the following best describes your current living situation?  
 In own home     renting     living with someone else     assisted living     hospital - date admitted: \_\_\_\_\_  
 Nursing facility or other institution - date admitted: \_\_\_\_\_     Other living situation: \_\_\_\_\_  
 Name of nursing facility, hospital or other institution: \_\_\_\_\_
- Have you ever been in a hospital or nursing facility for more than 30 days in a row?  
 No     Yes    If yes, when? (month/day/year through month/day/year): \_\_\_\_\_
- Are you a Veteran?  
 No     Yes    If yes, list VA claim number: \_\_\_\_\_
- Have you ever been married to a Veteran?  
 No     Yes    If yes, list name of Veteran spouse: \_\_\_\_\_
- Is anyone getting, or has anyone received medical, food or cash assistance, or tribal commodities in this or another state?  
 No     Yes    If yes, complete the following:  
 What benefits: \_\_\_\_\_ State: \_\_\_\_\_ Month/Year: \_\_\_\_\_
- Are any household members out of the home?  
 No     Yes    If yes, list name(s): \_\_\_\_\_  
 Why are they out of the home? \_\_\_\_\_  
 Date expected to return: \_\_\_\_\_

## B. Tell Us About Yourself and the People in Your Home (continued)



7. Are any household members affiliated with a Native American Tribe?  No  Yes If yes, what tribe? \_\_\_\_\_

Does your household live on a reservation?  No  Yes

**If you are applying for medical assistance only, skip questions 8-10 and proceed to section C.**

**The following questions are required by federal or state law for the purposes of the food and cash assistance programs only. If you answer yes to any of the questions below, make sure that you list the name(s) of the person(s) involved.**

8. Has anyone in your household been convicted of a drug-related felony occurring after August 22, 1996?

No  Yes If yes, list name(s): \_\_\_\_\_

9. Is anyone in your household fleeing from felony prosecution or jail?

No  Yes If yes, list name(s): \_\_\_\_\_

10. Is anyone in your household in violation of probation or parole?

No  Yes If yes, list name(s): \_\_\_\_\_

## C. Tell Us How You Want Us To Communicate With You



We provide interpreter and translation services. Complete this section to help us meet your needs. Does anyone in your household prefer to speak or read a language other than English?  No  Yes

If yes, write in the names of spoken and/or written language preferred below. Also include other communication needs such as braille, relay, signed English, TDD/TTY, Large Print, Voice Synthesizer Program, etc.

Name	Spoken Language	Written Language	Other Needs

## D. Tell Us About Your Medical Bills and Insurance



We need to know about your medical bills and any insurance coverage that you have to correctly determine your eligibility. Answer the following questions:

1. Do you have any unpaid medical bills from the past three months?

No  Yes If yes, list: \_\_\_\_\_

2. Do you want help with medical bills (including Medicare premiums) from the past three months?  No  Yes

3. Does anyone in your household have Medicare?  No  Yes If yes, complete the information below.

Refer to your Medicare Card:

Person Covered	Medicare Claim #	Type of Coverage check box(es)	Effective Date	Premium Amount	Plan Name
		Part A <input type="checkbox"/>			
		Part B <input type="checkbox"/>			
		Part D <input type="checkbox"/>			
		Part A <input type="checkbox"/>			
		Part B <input type="checkbox"/>			
		Part D <input type="checkbox"/>			
		Part A <input type="checkbox"/>			
		Part B <input type="checkbox"/>			
		Part D <input type="checkbox"/>			

## D. Tell Us About Your Medical Bills and Health Insurance (continued)



4. Is anyone in your household covered by health insurance?  No  Yes If yes, complete the following:  
 (Attach copies of your insurance cards - copy both sides.)

Person Covered	Name of Insurance Company	Type of Coverage (Hospital, Med, RX, Other)	List Monthly Premium Amount	Effective Date	Policy/Claim No.

## E. Who Eats With You



Food assistance households are based on persons who live together, and who buy and cook food together.

Do you (or will you after approval) buy and cook food separately from other people in your home?  No  Yes

If yes, please list their names and relationship to you: \_\_\_\_\_  
 \_\_\_\_\_

## F. Tell Us About Students In Your Home



Special rules apply to students. Complete this information to help us decide if these rules apply to your household.

Is anyone in your home a student in high school, college, or vocational-technical school?

No  Yes If yes, complete the following:

Student Name	Grade	Name of School	PT - Part Time FT- Full Time

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## G. Tell Us If You Want To Appoint Someone To Help With Your Case



You can name another person to help you get benefits. This person can help fill out the application, answer questions for you, and use the Vision card or Medical card for you. We will be able to share information with this person. The person can be a relative, neighbor, friend, durable power of attorney or other person you trust.

1. If you want to have someone help you, complete the information about this person below:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

What is this person's relationship to you (e.g., child, friend, attorney, etc.)? \_\_\_\_\_

**I appoint the above named person to be my representative to apply and manage my benefits. This person will receive copies of any letters sent about my case and be responsible for completing review forms and reporting changes:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

2. If you are approved for cash or food stamps, you will get a Vision Card to access your benefits. Do you want the person named above to have access to your benefits?  No  Yes If yes, which benefits?  Cash  Food Assistance  
If no, do you want to choose someone else to help get your cash or food assistance benefits?  No  Yes If yes, complete the following information for this person. This person will be your authorized representative. We will be able to share information with this person and this person can have access to your food and/or cash benefits.

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## H. Tell Us If You Are Disabled



We need to know if any persons in your household have a disability. Note: Personal Health Information disclosed here will only be used to determine your disability status and will not be shared with others. Complete the following:

1. Does anyone in your household have a disability?  No  Yes If yes, who: \_\_\_\_\_

**If No, proceed to Section I.** Note: If more than one person has a disability, answer questions for the second person on page 13.

2. Does this person get Social Security disability benefits?  No **Complete questions 3 through 6 below.**

Yes **Proceed to Section I**

3. Please describe the disability: \_\_\_\_\_

4. Do you think the disability will last more than 12 months?  No  Yes

5. Do you think the disability will result in death?  No  Yes

6. Has this person ever applied for Social Security benefits?  No  Yes If yes, complete the following:

a. Was the application denied?  No  Yes If yes, when: \_\_\_\_\_

b. Is the denial under appeal?  No  Yes If yes, status: \_\_\_\_\_

c. Has the existing condition become worse since the Social Security denial?  No  Yes If yes, explain: \_\_\_\_\_

d. Do you have a new disability or condition that Social Security did not look at?  No  Yes If yes, briefly describe the disability: \_\_\_\_\_

e. Is an attorney or someone else helping you with the Social Security application for disability benefits?  No  Yes  
If yes, list name of the person and organization: \_\_\_\_\_ Phone Number: \_\_\_\_\_

# I. Tell Us About Your Resources



We need to know about your resources to decide if you can get benefits. If needed, use page 13 to list more information.

1. Does anyone in your household own or have their name on any resources?

No  Yes If yes, complete the following. Mark no or yes on each item below.

Type of Resource		Name(s) on Resources	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union or Company)	Account No.
Cash	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Checking Account	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Savings/CD	<input type="checkbox"/> No <input type="checkbox"/> Yes				
IRA	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Nursing Facility Accounts	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Stocks and Bonds	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Funeral or Burial Plans	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Burial Plots	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you have a vehicle? <input type="checkbox"/> No <input type="checkbox"/> Yes Registered in Kansas? <input type="checkbox"/> No <input type="checkbox"/> Yes	Year: _____ Make: _____ Model: _____ Owner: _____ Year: _____ Make: _____ Model: _____ Owner: _____				

2. Does anyone in your home have life insurance?  No  Yes If yes, complete the following:  
(Include copies of all policies.)

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

## I. Tell Us About Your Resources (Continued)



3. Does anyone in your household own a home?  No  Yes If yes, fill out the following:  
Owners: \_\_\_\_\_ Location: \_\_\_\_\_  
Date Purchased: \_\_\_\_\_ Value: \_\_\_\_\_ Amount Owed: \_\_\_\_\_  
Who lives in this home? \_\_\_\_\_  
If the owner does not live there, explain why: \_\_\_\_\_  
If the owner does not live there, does the owner intend to return home?  No  Yes
4. Does anyone in your household own other land (including buildings, lots, farm ground, second homes)?  No  Yes  
If yes, complete the following:  
Describe Property: \_\_\_\_\_  
Location: \_\_\_\_\_  
Owner(s): \_\_\_\_\_ Value: \_\_\_\_\_ Amount Owed: \_\_\_\_\_
5. Does anyone in your household have a life estate or life interest in any property?  No  Yes  
If yes, complete the following:  
Describe Property: \_\_\_\_\_  
Location: \_\_\_\_\_ Owner(s): \_\_\_\_\_  
List date life estate created: \_\_\_\_\_ Value of Property: \_\_\_\_\_
6. Does anyone in your household have a trust?  No  Yes If yes, list type, owners, purpose and amount below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package?  No  Yes If yes, complete the following:  
Owner(s): \_\_\_\_\_ Value: \_\_\_\_\_  
Company: \_\_\_\_\_
- Note:** For Long Term Care assistance, the State of Kansas must be named as the beneficiary of any annuity you own which was purchased on or after February 8, 2006. More information will be given to you about this process. You agree to make this assignment when you sign the application.
8. Does anyone owe you money through a promissory note or other loans?  No  Yes If yes, explain:  
\_\_\_\_\_
9. Does anyone is your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc.)?  No  Yes If yes, complete the following. If needed, use page 13 to list more information.
- a. Describe Asset: \_\_\_\_\_  
Owner(s): \_\_\_\_\_ Value: \_\_\_\_\_
- b. Describe Asset: \_\_\_\_\_  
Owner(s): \_\_\_\_\_ Value: \_\_\_\_\_
10. Have you or your spouse taken a loan against any property in the last five years, including a second mortgage?  
 No  Yes
11. Have you or your spouse ever waived rights to an inheritance or will?  
 No  Yes

## I. Tell Us About Your Resources (Continued)



12. Have you or your spouse changed ownership, sold or given away any asset in the last five years (such as cash, CD's, stock, house, land, or any other assets)?

No  Yes If yes, complete the following:

Date Ownership Changed	Type of Asset	Value	Given/Sold To	Purpose

## J. Tell Us About Your Earned Income



We need to know about all income from jobs, self-employment, contract labor, etc. Is anyone in your household self-employed or working at a job?  No  Yes If yes, complete the information below for all jobs. Self-employment includes earnings from odd jobs, child care, lawn mowing, snow removal, cosmetic sales, etc. If needed, use page 13 to list more information.

Name	Employers Name, Phone & Address (if self-employed, list type of business)	Salary or Hourly Wage	Tips or Commission	Weekly Hours Worked	How often do you get paid?	Day of the week paid

Do you have special expenses related to your disability that help you work? (Examples include service dogs, attendant care, specialized transportation for work, etc.)  No  Yes If yes, complete the following:

Type of Expense	Amount of Expense	How Often Paid?

Has anyone in your household lost or quit a job in the last 60 days?  No  Yes If yes, complete the following:

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Last Work Day: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_

## K. Tell Us About Your Other Income



We also need to know about all other income in your household to decide if you can get benefits.

Complete the following chart. Mark no or yes on each item below. If needed, use page 13 to list more information.

Type/Source of Income		Name of Person Who Receives This	Amount Received (before deductions)	How Often Received	Claim No.
Social Security Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	1.			
	<input type="checkbox"/> No <input type="checkbox"/> Yes	2.			
	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.			
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	1.			
	<input type="checkbox"/> No <input type="checkbox"/> Yes	2.			
Veteran's Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Railroad Retirement	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Trust Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Annuity Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other Retirement or Pension. Source: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Worker's Compensation/ Unemployment	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Oil Royalties/ Mineral Rights/ Tribal Payments	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Contract Sale/ Rental Income	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Other Income Source 1: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Source 2: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes				

Has anyone applied for other income or benefits?  No  Yes

If yes, list who and what income or benefits: \_\_\_\_\_

**Agency Use Only**

## L. Tell Us About Your Household Expenses



To help us decide the correct amount of food assistance benefits, tell us about your shelter and other expenses.

Type of Expense	Amount	Who Pays?
Do you rent your home? <input type="checkbox"/> No <input type="checkbox"/> Yes If renting, list landlord's name, address and phone: _____ _____		
Do you own or are you buying your home? <input type="checkbox"/> No <input type="checkbox"/> Yes What is the amount of your monthly rent or house payment? ..... \$		
If renting, is this subsidized housing, Section 8, HUD, other? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, tell us the amount you are obligated to pay each month ..... \$		
Do you pay property taxes not included in house payment? <input type="checkbox"/> No <input type="checkbox"/> Yes	\$	
Do you pay homeowner's insurance not included in house payment? <input type="checkbox"/> No <input type="checkbox"/> Yes	\$	
Do you pay child or dependent care? <input type="checkbox"/> No <input type="checkbox"/> Yes	\$	
Do you pay child support? <input type="checkbox"/> No <input type="checkbox"/> Yes List amount paid and court order number for each child: _____	\$	
If you are 60 or older, or disabled, do you have any medical expenses? <input type="checkbox"/> No <input type="checkbox"/> Yes Include health insurance and Medicare Premiums. Use page 13 to list more information.	\$	
Do you have any utility expenses? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have a heating or cooling expense? <input type="checkbox"/> No <input type="checkbox"/> Yes If no, check the following utilities you are responsible to pay: <input type="checkbox"/> Water <input type="checkbox"/> Sewer <input type="checkbox"/> Trash <input type="checkbox"/> Telephone <input type="checkbox"/> Electricity/gas for cooking or lights <input type="checkbox"/> Other _____ <input type="checkbox"/> None		
Have you received Low Income Energy Assistance (LIEAP)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes when: _____		
Does any one help you pay the above expenses? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what expenses do you get help with? _____ How much do they pay? _____		

**Agency Use Only**

## Please read this information before signing Page 12



### Rights, Responsibilities, and Penalties

- I have read and understand my rights and responsibilities listed on the tear off page at the end of this form.
- I understand the questions on this application form.
- I understand the penalties for hiding information (penalties are shown on the tear off page at the end of this form).
- I understand the penalties for giving false information (penalties are shown on the tear off page at the end of this form).

### Citizenship Status

- Signing this form means that I agree everyone living in my home who is asking for assistance is a U.S. citizen or is in legal immigration status. I understand this requirement does not apply to persons asking for Emergency Medical Assistance (SOBRA Program).

### Changes You Must Report

- I agree to report changes such as changes in my address, income changes, and changes in individuals who live in my home.
- I understand my worker will send me a notice about the changes I am required to report.
- I will let my worker know of changes that might affect my eligibility or benefit level.

### We Will Verify the Information You Give Us

- I understand you will verify the information I provide on this application form.
- I understand you may contact other agencies such as federal, state, local officials, employers, medical providers, businesses, financial organizations, and child care providers to verify information.
- I understand you will use the information you verify and that it could affect my eligibility or benefit level.

## Information about Social Security Numbers



- I understand that I have to provide or apply for a Social Security Number for people in my household who are asking for assistance.
- I understand Social and Rehabilitation Services (SRS) and the Kansas Health Policy Authority (KHPA) use Social Security Numbers to operate. The numbers are used for computer matches with the Social Security Administration, banks, the Internal Revenue Service, and other organizations and agencies.

## Information about Food Assistance Expenses



- I understand I must report and verify my household expenses or I will not get a deduction for them.

## Information about Cooperation



- I agree that everyone applying for and receiving cash or medical assistance and who claims to be disabled must cooperate with determining presumptive medical disability.
- I understand we may not receive cash assistance if someone does not cooperate.

## Information about Medical Assistance Coverage



- I understand the Kansas Health Policy Authority (KHPA) is responsible for administering the medical assistance program.

### Third Party Resources

- I understand that the Kansas Medical Assistance Program (Title XIX and Title XXI) will only pay for services not covered by other insurance or other third parties.
- I am responsible for using and reporting all third party resources for everyone in my home who receives medical assistance. Examples of third party resources are health insurance coverage, a court settlement, medical support payments, a trust, or a conservatorship. These sources may be legally responsible for paying some of the medical expenses of a person.
- I understand that you may not pay for medical services if you believe a third party resource was not used first.
- I agree to help you go after all third party resources. The Medical Subrogation Unit goes after other parties for payment of medical services. I will help this unit pursue all third party resources.

### Payments and Support

- If we are approved for medical assistance, we agree to let payments for medical services go directly to our physicians and other medical providers.
- If we are approved for medical assistance, we will turn over to the Kansas Health Policy Authority (KHPA) any medical support payments we get.

## Information about Medical Assistance Coverage (Continued)



### Estate Recovery Provisions - The following DOES NOT apply to the Medicare Saving Programs.

- If anyone receives medical assistance after age 54 or while in an institution, I understand there may be a claim against the estate of the recipient or spouse to recover the medical expenditures made on their behalf.
- I understand you will tell all of our financial institution(s) and other investment companies about your pending claim on the estate.

### Health Department Referral

I give my permission for my name and the names of those on my case, our address, telephone number, and eligibility status to be given to medical providers and local health departments so that they may give us information about services they provide.

No  Yes

## Permission to Release Information



My signature on this application authorizes employers, health care providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances to release to the Kansas Department of Social and Rehabilitation Services (SRS) and to the Kansas Health Policy Authority (KHPA) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program for which I applied.

I authorize SRS and KHPA to share medical information for administrative purposes with other agencies and contractors.

I understand all information provided on this application and all information provided to SRS or KHPA staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

**I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.**

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Your Spouse's Signature or another adult in your home (Not Required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of First Witness (if "X" is used)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Second Witness (if "X" is used)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Court-Appointed Guardian/Conservator (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Medical Representative (if applicable)

\_\_\_\_\_  
Date

## Kansas Voter Registration Information



This section will not affect the assistance or services that you can receive from SRS or KHPA. If you do not check any of the boxes, you will be considered to have decided not to register to vote at this time.

Would you like to register to vote today?  No  Yes  Already registered where I live now.

SRS and KHPA will be glad to help you with the voter registration application. If you have additional questions or need to report a problem, you may contact your county officer, Secretary of State's office, or call 1-800-262-VOTE (8683).

Use this space to write additional information.

**Kansas Department of Social and Rehabilitation Services**  
**Application for Benefits for the Elderly and Persons with Disabilities**  
**Rights and Responsibilities - Read and Tear Off for Your Records**

**Processing times for your application are:**

- within 30 days for food assistance;
- within 45 days for cash and medical assistance;
- within 90 days for presumptive medical disability.

If you are eligible, benefits will start from the date a signed application is received in the SRS office.

You may be able to get food assistance within 7 calendar days if you qualify. We will let you know if you qualify for this special processing.

The following information applies to all programs:



**Your Responsibilities:**

**You have a responsibility to:**

- provide all information needed to determine your eligibility;
- report changes as required - we will tell you what must be reported (examples include someone leaving or moving into your house, change of income, selling property, moving into a nursing home, new address, etc.);
- use, and report to SRS, any resources that could help pay for your family's medical expenses (examples include insurance policies, money won through lawsuits, or medical support payments)(medical and cash assistance only);
- cooperate with Quality Assurance staff if your case is reviewed.

**Your Rights:**

**You have a right to:**

- have an interpreter provided at no cost if English is not your preferred language;
- have information given to SRS kept confidential, unless directly related to the administration of SRS programs;
- withdraw your application at any time;
- request a fair hearing within 30 days for cash and medical assistance, or within 90 days for food assistance if you disagree with the decision;
- have your benefits determined from the date this application is received by SRS;
- special considerations and confidential services, if you are in danger of domestic violence or sexual assault; and
- In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.
- To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

**SRS Rights:**

**SRS has a right to:**

- use the information on this application, including the Social Security Number (SSN) of each person in your home, to decide whether your household can get benefits. We will verify this information through computer matching programs. This information will also be used to make sure you are getting the correct amount of benefits.
- deny benefits to your household if you do not provide requested information;
- disclose the information on your application to other federal and state agencies for official examination, and to law enforcement officials for the purpose of catching people who are running from the law. You or members of your household will not, however, be reported to the Bureau of Immigration & Customs Enforcement (formerly INS);
- refer the information on this application to federal and state agencies, as well as private claims agencies, for claims collection if overpayments arise against your household;
- conduct a full investigation of your eligibility including contacting employers, banks, doctors, or by visiting your home;
- deny your application or prosecute you for fraud if you knowingly give us false information so you can receive assistance; and
- give information to the Kansas Health Policy Authority to administer medical assistance.

## Penalties

You should also know that:

Persons may lose benefits for not cooperating with the following agency programs:

- Food Assistance Work Programs - looking for work, preparing for employment, and keeping a job (if applicable).

Any member of your household who intentionally breaks the following rules may not get cash or food assistance for one year for the first offense, two years for the second offense, and permanently for the third offense. If you are applying for food assistance you may also be fined up to \$250,000 and/or jailed up to 20 years, as well as barred from the Food Assistance Program for an additional 18 months if court ordered, may lose deductions, and may be prosecuted under other laws.

- Do not lie or hide information to get benefits that your household should not get.
- Do not use food assistance benefits to buy nonfood items, such as alcohol or cigarettes, or to pay on credit accounts.
- Do not use, or have in your possession, Vision Cards that are not yours.
- Do not trade or sell Vision Cards, or use someone else's card.
- If you buy, sell, or trade more than \$500 in food assistance benefits, you may be barred permanently from the Food Assistance program. If a court of law finds you guilty of trading food assistance benefits for firearms, ammunition, explosives, or controlled substances, you will be subject to:
  - loss of benefits for two years for the first offense, and permanently for the second offense involving the sale of a controlled substance; and
  - permanent loss of benefits for the first offense involving the trading of firearms, ammunition, or explosives.

If you make false or misleading statements about where you live to get duplicate food assistance or cash benefits, you may not be able to get food assistance or cash benefits for 10 years. In addition, if you make false or misleading statements about who you are to get duplicate food assistance benefits, you may not be able to get food assistance benefits for 10 years.

## Interview



For food and/or cash assistance, we require an interview as part of the application process. An interview is not required for medical but you may ask for one.

- Your interview has been scheduled at: ----->
- Your interview date and time is - Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Please call for an interview appointment: \_\_\_\_\_
- Other: \_\_\_\_\_

## Information Needed to Process Your Application



We may ask you to provide some or all of the following items. Please be ready to provide this information.

- Proof of where you live.
- Proof of age and identity.
- Proof of citizenship for those who want to receive benefits.
- Proof of non-citizen status for those who want to receive benefits.
- Dependent care bills and receipts.
- Proof of child support and/or alimony paid or received.
- Proof of income (pay stubs, earning statements, rental property/sales contracts, Government payments, Workers Compensation, pensions, and other).
- If self-employed, federal income tax returns, bookkeeping records, sales, and expenditure records.
- Life insurance and burial plans.
- Rent receipt/house payment (including insurance and property taxes).
- Proof of medical expenses such as medication, doctor bills and hospital bills.
- Health insurance cards and premium information.
- Bank statements for checking accounts, savings accounts, or stocks/bonds/mutual funds.
- Proof of trusts and annuities.
- Other: \_\_\_\_\_

If you have any questions, or need help completing the application, call us toll free at 1-888-369-4777.