



Making things BETTER for Kansas kids

Welcome to HealthWave!

HealthWave

1-800-792-4884

TTY 1-800-792-4292
(for people with hearing impairments)

Questions? Call HealthWave

The call is free.

Monday - Friday, 7 am - 7 pm

Saturday, 8 am - 5 pm

HealthWave is a program for children in families with limited incomes that provides health insurance at little or no cost.

Children in the HealthWave program will get regular checkups, doctor visits, shots, dental and eye exams, hospital care, mental health services, and many other services. Children must be:

- under age 19 (If 18, a separate application must be completed)
- a resident of Kansas
- living in a family whose income meets the HealthWave guidelines (approximately \$3,000 a month for a family of 4). The family includes the child(ren) for whom you want coverage and their parent(s).

To apply for HealthWave:

- 1 Fill out this form. If you need more space, attach extra sheets of paper.
- 2 **Attach COPIES of all documents asked for.**
- 3 **Sign the form.** Your application is not complete until it is signed. *Any extra sheets must also be signed.*
- 4 Mail the form in the self-addressed, stamped envelope provided. The address is:

**Health Wave
PO Box 3599
Topeka, Kansas 66601**

Agency Use Only:

Date Received	Date Registered
Specialist	
Case Number	

1. List the person who is the head of this household (parent, guardian, other adult relative, etc.)

First Name	Middle Initial	Last Name	Home Phone	Work Phone	Message Phone
Street Address		City	State	County	ZIP Code
Mailing Address (if different from above)		City	State	County	ZIP Code

2. List all children under 19 living in the home. **Mark which children you want coverage for.** If someone does not have a Social Security number, but has applied for one, send proof of application. If the child(ren) is not a U.S. citizen, proof of immigration status will need to be provided, and you will be contacted further about this.

a	Child's First Name	MI	Last Name	Birth Date	Sex	Race (optional)	Do you want coverage for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number (if child has one)		U.S. Citizen? (Yes or No)		Mother's Full Name		Father's Full Name	

b	Child's First Name	MI	Last Name	Birth Date	Sex	Race (optional)	Do you want coverage for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number (if child has one)		U.S. Citizen? (Yes or No)		Mother's Full Name		Father's Full Name	

c	Child's First Name	MI	Last Name	Birth Date	Sex	Race (optional)	Do you want coverage for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number (if child has one)		U.S. Citizen? (Yes or No)		Mother's Full Name		Father's Full Name	



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3. Is anyone listed in Section 2 pregnant? Yes No If yes, please send verification from your doctor.

Name of Pregnant Person	Due Date
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4. List all adults living in the home. (List head of household in space "a".)

a	Adult's First Name	Middle Initial	Last Name	Date of Birth	Sex	Race (optional)
	Social Security Number (optional)	Relationship to Children in Section 2	Relationship to Head of Household	Self		Other Names Used <small>(Maiden name, Prior Married Name, etc.)</small>

b	Adult's First Name	Middle Initial	Last Name	Date of Birth	Sex	Race (optional)
	Social Security Number (optional)	Relationship to Children in Section 2	Relationship to Head of Household			Other Names Used <small>(Maiden name, Prior Married Name, etc.)</small>

c	Adult's First Name	Middle Initial	Last Name	Date of Birth	Sex	Race (optional)
	Social Security Number (optional)	Relationship to Children in Section 2	Relationship to Head of Household			Other Names Used <small>(Maiden name, Prior Married Name, etc.)</small>

5. Is anyone in the household working (including self-employment and seasonal employment)? Yes No
If yes, complete below and send copies of pay stubs for the past 2 months for all employed persons, or send a letter signed by the employer stating the following:

- date of check
- time period each check covers
- gross amount of each check (before taxes/other deductions)
- an estimate of the wages if a paycheck has not been issued

Is anyone in the household self-employed? Yes No
For seasonal employment or self-employment, send a copy of last year's federal income tax return with all attachments.

a	Name of Person Working	Name of Employer	Employer's Address
	Employer's Phone	Hourly Wage or Amount of Salary	Number of Hours Worked / When Paid? (weekly, biweekly, monthly, etc.)

b	Name of Person Working	Name of Employer	Employer's Address
	Employer's Phone	Hourly Wage or Amount of Salary	Number of Hours Worked / When Paid? (weekly, biweekly, monthly, etc.)

c	Name of Person Working	Name of Employer	Employer's Address
	Employer's Phone	Hourly Wage or Amount of Salary	Number of Hours Worked / When Paid? (weekly, biweekly, monthly, etc.)

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6. Is there other income? Yes No If yes, complete information below and send proof (benefit letter, copy of a check from the payer, etc.).

Type of Income	Amount	How Often Received?	Who Is Payment For?
SSI			
Child Support/Alimony			
Social Security			
Unemployment Compensation			
Other			

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7. Does anyone have health insurance (including insurance through an employer or absent parent)? Yes No If yes, complete below.

a	Who Is Covered?	Name of Insurance Company	Address		
	Type of Coverage (hospital, doctor, prescription, dental, etc.)	Start Date	Policy Number	Group Number	Policy Holder

b	Who Is Covered?	Name of Insurance Company	Address		
	Type of Coverage (hospital, doctor, prescription, dental, etc.)	Start Date	Policy Number	Group Number	Policy Holder

c	Who Is Covered?	Name of Insurance Company	Address		
	Type of Coverage (hospital, doctor, prescription, dental, etc.)	Start Date	Policy Number	Group Number	Policy Holder

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8. Has health insurance ended for any child in the past six months? Yes No If yes, complete below.

a	Who Was Insured	Name of Insurance Company	Type of Coverage (hospital, doctor, prescription, dental, etc.)		
	When Did Coverage End	Why Did Coverage End?			



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8. Continued.

b Who Was Insured?	Name of Insurance Company	Type of Coverage (hospital, doctor, prescription, dental, etc.)
When Did Coverage End?	Why Did Coverage End?	
c Who Was Insured?	Name of Insurance Company	Type of Coverage (hospital, doctor, prescription, dental, etc.)
When Did Coverage End?	Why Did Coverage End?	

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9. Does any child have unpaid medical bills? Yes No

If yes, do you want to see if we can help with these? Yes No If yes, you will be contacted further.

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10. Important conditions and authorization to release information:

- I understand I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.
- I understand I have the right to have information I have provided kept confidential unless directly related to the administration of HealthWave or other benefit programs.
- I understand I have the right to request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.
- I understand that I may have to provide or apply for a Social Security number for the children for whom I am applying and authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the Social Security Administration and the Internal Revenue Service.
- I certify that all children for whom I am applying for health coverage and who are determined eligible for such coverage are U.S citizens or are aliens in lawful immigration status.
- I agree to report any changes, including changes in income, household composition, address, or living arrangements within 10 days of the change.
- I understand I have the responsibility to use and report any third party resources (such as health insurance, court settlements, medical support payments, trusts, conservatorships, etc.) that may have a legal obligation to pay any or all of the medical expenses of the children for whom I am applying. I understand that payment for a particular service may be withheld while a determination of failure to use a third party resource is made.
- I understand that some or all of the children for whom I am applying may receive similar health coverage under the Medicaid program if eligible.
- I authorize payments under this program to be made directly to physicians and other medical providers on any medical and other health services furnished to the children for whom I am applying while eligible.
- I understand the questions on this application and I understand there are penalties for hiding information or giving false information.
- I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.

My signature on this application signifies that I have read and understand the conditions above. It also authorizes employers, medical providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to HealthWave or other benefit programs any information, including confidential information, necessary to establish my eligibility. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from the date set out below. A copy of this authorization is as valid as the original.

Sign below:

_____	_____
Head of household	Date

When your application is filled out and signed, send it to: HealthWave, PO Box 3599, Topeka, Kansas 66601