

INFORMATION DISCLOSURE FORM

Parent Fee Program – Home and Community Based Services (HCBS) Waiver

A. Child(ren) Information

Please complete the following for each child under the age of 18 receiving services through a HCBS Waiver.

Child's Full Name (First, Middle Initial, Last)	Date of Birth (Mo/Day/year)	Medicaid ID Number	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check the appropriate line below to indicate in which HCBS waiver your child(ren) are enrolled:

- DD Waiver** for Children with Mental Retardation or a Developmental Disability
 TA Waiver Technology Assistance for Children who depend on technology for life
 SED Waiver for Children with a Severe Emotional Disturbance

B. Parent Information

Name of Parent(s): _____

Address: _____ City, State, Zip: _____

Daytime Phone Number (_____) _____ Parent's SSN: _____

1. Were you required to file a federal income tax return for last year? Yes ____ No ____
2. If "Yes", please attach a copy of the first page of your Federal Income Tax Return. If "No", please estimate, below.
3. Total Number of Exemptions Claimed # _____ Adjusted Gross Income \$ _____

I do not believe a Parent Fee should be charged for the following reason(s). Check **all** that apply.

- Child is over 18 Child is in foster care or some other residential placement
 Child is adopted I am a relative other than a parent or step-parent
 Waiver has been officially discontinued with an effective date of ____/____/____

C. The information I have given on this form is true and correct to the best of my knowledge.

Signature _____ Date _____

Please mail to: SRS, Health Care Policy - Parent Fee Program
 915 SW Harrison, DSOB 10th Floor
 Topeka, KS 66612-1570

Contact for Questions
 Phone: (785) 296-3536