

INFORMATION DISCLOSURE FORM

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

(Print in Black or Blue Ink)

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 in foster care or some other residential placement
 Child is adopted
 I am a relative other than a parent or step-parent

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, DBHS - Parent Fee Program
 915 SW Harrison, DSOB 9th Floor
 Topeka, KS 66612-1570

Contact for Questions
 Phone: (785) 296-3536