PLEASE PRINT IN BLUE OR BLACK INK ONLY

For Agency Use Only:

Date Received_____

Case Number _____

1. **Tell us about yourself:** If you are applying for children only, a parent, guardian or adult household member must be listed.

Legal Name: _____ List any other names used: _____

Home address: _____ Apt. or Lot #: _____ City: _____ County: _____ State: ____ Zip Code: _____

Mailing address (if different): _____ City: _____ State: _____ Zip Code: _____

Home #: (____)_____ Message/Cell phone #: (____)_____ Work #: (____)_____ Is it ok to call you at work? **No** ____ **Yes** ____

2. **Tell us about everyone living in your home:** Start with yourself on line #1. Mark each person you want covered and provide their Social Security Number (SSN). Listing the SSN for everyone in your home may help us serve you better. Use a separate sheet of paper if you need more space.

Applying for		Legal Name (if pregnant, list "unborn child" on a separate line)	If pregnant, indicate expected due date	Relationship to Person #1	Sex	Social Security Number	Date of Birth	U.S. Citizen?		Race/ Ethnicity (optional)	Full Name of Parents – Complete for persons under the age of 19, including unborn children	
No	Yes							No	Yes		Father	Mother
		1.		self								
		2.										
		3.										
		4.										
		5.										
		6.										

3. **Tell us about your income:** Proof of all income, before deductions, is required.

Does anyone in your household have a job or is self-employed? No ____ Yes ____ If yes, fill out the chart below for all jobs. Proof of all income, before deductions, is required. Examples include copies of pay stubs, a statement from your employer, etc. If you work for yourself (self-employed), you must provide your most recent complete tax return, if filed. A statement of income and expenses for the last three months for your business is required if you do not have a tax return.

Name of Wage Earner	Company Name, Address and Phone (if self-employed list type of business)	Salary or Hourly Wage	Tips, Commission, or Bonus	Hours Worked Weekly	How often do you get paid?	Day of the Week Paid	Date of Next Paycheck	For Self-Employed Persons Only	
								Monthly Income (Before Expenses)	Monthly Business Expenses

Does anyone in your household, including children, receive income such as child support, alimony, unemployment, Social Security/SSI, worker's compensation, veteran's benefits, etc.? No ____ Yes ____ If yes, fill out the chart below for each person receiving income. Proof of income is required. Provide copies of benefit letters, court orders, Kansas Payment Center printouts, etc.

Name of Person Receiving Income	Type/Source of Income	Amount Received (Before Deductions)	How Often Received	Claim/Court Order Number

4. **Does anyone in your household have a trust fund? No ____ Yes ____** If we need more information, we will contact you.

5. **Do you pay someone to watch a family member while you work? No ____ Yes ____** This information is not used for all programs. We will contact you if needed.

6. **Does anyone you are applying for have unpaid medical bills from the past 3 months? No ____ Yes ____** If yes, please list total amount: _____
Would you like us to find out if you qualify for coverage for the past 3 months? No ____ Yes ____ If yes, provide proof of income for each of the past 3 months.

7. **Does anyone you are applying for have health insurance of any kind (other than Medicaid and/or HealthWave)? No ____ Yes ____** If yes, fill out the chart below and provide copies of the insurance card (both sides).
If health insurance has ended for anyone you are applying for in the past six months, please explain why. _____

Name of Insurance	Policy Holder	Persons Covered	Type of Coverage (Hospital, Dental, Other)	Start Date	End Date	Policy Number & Group Number

8. **Do you prefer a language other than English? No _____ Yes _____** If yes, please list. Written: _____ Spoken: _____
Do you use other media to communicate, such as sign language, Braille, TDD, other? No ____ Yes ____ If yes, please list. Other Media: _____

9. **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 19 (Medicaid), HealthWave 21, or other benefit programs.

I understand that I have to provide or apply for a social security number for anyone who is applying for health benefits and I 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 Internal Revenue Service.

I certify that everyone I am requesting health coverage for and who is determined eligible for such coverage is a U.S. citizen or is a non-U.S. citizen in lawful immigration status. Proof of immigration status may be required.

I understand it is important to provide current income, address and household composition information and I am responsible for reporting changes while eligible.

I understand that some or all of the people for whom I am applying may receive similar health coverage under the Medicaid program, if eligible.

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 those 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 any payments made to me by a third party resource for medical services covered under the HealthWave 19 (Medicaid) and HealthWave 21 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.

I understand that if I receive medical assistance after age 54 or while in an institutional arrangement, there may be a claim against my estate to recover the medical expenditures made on my behalf. I understand that my financial institution(s) will be notified of a pending claim.

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 those 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.

If applying for adults and children and if any of those adults are determined eligible for medical coverage, I agree to help Child Support Enforcement (CSE) in establishing and enforcing support orders (if needed).

If the adults in the household are eligible for medical assistance, I agree to turn over any medical support payments for all persons receiving medical assistance.

I authorize medical providers under this program to release medical information to the Division of Health Policy and Finance (DHPF), the Department of Social and Rehabilitation Services (SRS), the U.S. Department of Health and Human Services, insurance companies and other contracted medical providers. I also authorize DHPF and SRS to share medical information for administrative purposes with other agencies and contractors.

This is an application for HealthWave 19 (Medicaid) and HealthWave 21 only. You may apply for other medical programs, such as elderly and disabled programs, at your local SRS office.

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.

10. **Signature:** This application must be signed and dated in order to be considered a complete application.

_____
Signature of Applicant (Required) Date

_____
Signature of Spouse or Other Adult (If Applying) Date

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 this date. A copy of this authorization is as valid as the original.

11. **Kansas Voter Registration Information:** This section will **not** affect the assistance that you can receive. 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 _____** DHPF or SRS 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 election officer, Secretary of State's office, or call 1-800-262-VOTE.