

Kansas Department for Children and Families

Review Form for Elderly and Persons with Disabilities

This form provides us with the information we need to determine your family's continued eligibility. If you want to apply for additional programs and services, you will need to contact the service center to request a separate application. Answer all of the questions to the best of your ability. If English is not your primary language, an interpreter will be provided at no cost to you. You are subject to severe penalties for any false or misleading information you supply on this application.

Agency Use Only

Date Received: _____

Date Interviewed: _____

Case Number: _____

FA GA Medical

Was the review received following the end of the review period? No Yes

If yes, is the household eligible for expedited service? No Yes

Household Information

Name: _____

First Name, Middle Initial, Last Name

Mailing Address: _____ City: _____ County: _____ Zip: _____

Daytime Phone: _____ Message Phone: _____

List all persons who live with you. List yourself first. (Use an additional sheet to list more household members.) Student status includes grade school, high school, college or vocational-technical school.

First Name, MI, Last Name	Relation to You	Are you applying for this person?	Sex M/F	Birth Date	Social Security number	Student	US Citizen
	Self	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Household Information (continued)

Complete this question only if reapplying for Food Assistance. 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: _____

Has anyone moved in or out of your household? No Yes If yes, please list the name and date in which they entered or left the household: _____

Is anyone in your home disabled? No Yes If yes, please list name and disability: _____

Which of the following best describes your current living situation?

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: _____

Do you intend to return to your home? No Yes

Complete this question if reapplying for Medical Assistance. Are you a veteran or been married to a veteran?

No Yes If yes, list VA claim number or spouse's name: _____

If you receive medical assistance through the General Assistance program, complete the following questions:

Has the existing condition become worse or do you have a new disability or condition?

No Yes If yes, describe: _____

Is your attorney/legal organization helping you with the Social Security application for disability benefits?

No Yes If yes, list your attorney/legal organization and the phone number: _____

The following questions are required by federal law for purposes of the food assistance program only. If you answer yes to any of the questions, make sure to list the name(s) of the persons involved.

Has anyone in your household been convicted of trading food assistance benefits for drugs after September 22, 1996?

No Yes If yes, list name(s): _____

Has anyone in your household been convicted of buying or selling food assistance benefits over \$500 after September 22, 1996?

No Yes If yes, list name(s): _____

Has anyone in your household been convicted of fraudulently getting duplicate food assistance benefits in any state after September 22, 1996?

No Yes If yes, list name(s): _____

Has anyone in your household been convicted of trading food assistance benefits for guns, ammunitions, or explosives after September 22, 1996?

No Yes If yes, list name(s): _____

Authorized Representative

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: _____ Email 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 about my case and will be responsible for completing review forms and reporting changes:

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

2. If you are approved for food assistance, 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 no, do you want to choose someone else to help get your 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 assistance benefits.

Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Medical Bills and Insurance

Is anyone in your household covered by health insurance other than Medicare or Medicaid? No Yes

If yes, complete the following:

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

Resource Information

Does anyone in your household own or have their name on any resources? For example: cash, checking/savings/credit union accounts, certificates of deposit (CD's), stocks, bonds, IRA's, property or any other resources?

No Yes If yes, complete the following information. **If reapplying for Medical Assistance, include your most recent bank statement for your checking and savings accounts.**

Type of Resource	Name(s) on Resources	Where is Resource Held? (Name of Bank, Credit Union or Company)	Amount or Value

Does anyone in your household own any property? No Yes If yes, list below any home, land, other real estate, cabins, life estate or life interest in any property, trust, or similar investment or other assets owned by you or anyone in your household.

Type of Property or Asset	Owner's Name	Value
		\$
		\$
		\$
		\$

Complete this question if reapplying for Medical Assistance. Are any vehicles owned or being purchased by you or anyone in your household? No Yes If yes, list below all vehicles owned or being purchased by you or anyone in your household (include cars, trucks, boats, motorcycles, RVs, ATVs, etc.).

Owner's Name	Type of Vehicle	Model/Year	Amount Owed	Current Value
			\$	\$
			\$	\$
			\$	\$
			\$	\$

Have you or your spouse transferred any money, assets or property within the last 5 years? No Yes

If yes, please explain: _____

Income Information

Is anyone in your household self-employed or working at a job? No Yes

Complete the information below for you or anyone in your household who is working. **Please attach pay stub for the past 30 days for each job. If you are self-employed, attach a copy of your tax return for the past year or verification for business income and expenses for the past 3 months.**

Name of Person Employed	Employers Name, Phone & Address (if self-employed, list type of business)	Salary or Hourly Wage	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 dog, 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 Last pay: \$ _____ Date _____
 Name(s) _____ Employer _____
 Last Work Day(s): _____ Reason(s): _____

Do you or anyone in your household have other income? No Yes If yes, list any monies you or anyone in your household receives (include Social Security, SSI, VA, railroad retirement, other pension/retirement benefits, worker's compensation, unemployment benefits, tribal payments, oil or mineral rights, contract sale/rental income, cash gifts, money from others or any other income):

Type/Source of Income	Name of Person Who Receives This	Amount Received	How Often Received

Has anyone applied for other income or benefits? No Yes

If yes, list who and what income or benefits: _____

Household Expenses

Complete this section if you or anyone in your household has any of these monthly expenses:

Expense Type	Monthly Amount
Rent/Mortgage (circle one)	
Lot or Rent Space	
Property taxes not included in mortgage	

Expense Type	Monthly Amount
Homeowner's Insurance not included in mortgage	
Dependent Care	
Other	

If renting, is it subsidized housing, Section 8, HUD, or other? No Yes If yes, tell us the amount you are obligated to pay: \$_____

Do you have a heating or cooling expense? No Yes

If no, check the following utilities you are responsible to pay:

Water Sewer Trash Telephone Electricity/gas for cooking or lights Other None

Have you or anyone at your residence received Low Income Energy Assistance (LIEAP)?

No Yes If yes, when: _____

If you share payment of these expenses with anyone, please explain: _____

Does anyone in your household pay child support? No Yes If yes, please provide proof of payment for the past 3 months.

Who Pays Child Support	Amount Paid	Court Order Number for Each Child

Do you expect any changes in your household expenses or circumstances? No Yes

If yes, please explain: _____

If you or a household member is 60 or older or disabled, do you have personal out of pocket medical expenses in excess of \$35 per month? No Yes If yes, who has the medical expenses and what are they? _____

Please Read This Information Before Signing Page 11

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, changes in child care, and changes in individuals who live in my home.
- I understand I will be notified about the changes I am required to report.
- I will tell DCF 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 Department for Children and Families (DCF) and the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) 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 Child Support Services

- I agree to help Child Support Services (CSS) go after support for the children in my home. I will help CSS establish and enforce support orders for the children.
- I agree to give all alimony and/or child support to DCF for each person in my home receiving cash assistance.
- For medical assistance, I understand this rule only applies to me if both adults and children are found eligible for assistance.

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 Work Program Cooperation

- I agree that everyone applying for and getting cash assistance will cooperate with work requirements unless exempt.
- I agree that everyone getting food assistance will cooperate with work requirements, unless exempt.
- I understand we may not get cash assistance if someone does not cooperate.
- I understand that the person who does not cooperate may also not get food assistance.

Information About Cash and Food Assistance Benefits

- I understand that I may not use cash assistance benefits to purchase alcohol, tobacco or lottery tickets.
- I understand the time limit for receiving Temporary Assistance for Needy Families (TANF) cash assistance benefits is 48 months.
- I understand that to get TANF cash assistance, all children in the home ages 7-18 must be enrolled in school, including home school that is registered with the Kansas Department of Education. Ineligibility for the entire household will exist if a child in the home is not enrolled in school.
- I understand I may not use food assistance benefits to buy non food items, such as alcohol or cigarettes, or to pay on credit accounts.

Information About Medical Assistance Coverage

- I understand the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) 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 pay only 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 Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) any medical support payments we get.

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

- If anyone receives medical assistance after the 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

Information About the Lifeline Telephone Program

- For cash (Temporary Assistance for Families) and food assistance, I agree that DCF may provide my name, address, and telephone number to telephone companies participating in the Lifeline data match. The Lifeline Program provides basic telephone service at a reduced rate.
- I understand that my information is confidential and will only be used by the participating telephone carriers to verify my eligibility for Lifeline telephone assistance.
- I understand that the Lifeline program is not mandatory and that I will have to apply for this service by contacting my local telephone company.
- I understand that not all telephone carriers participate in the Lifeline data match with DCF and that I may have to provide proof of my household income to my local telephone company for them to determine my Lifeline eligibility.

Kansas Voter Registration Information

This section will not affect the assistance or services that you can receive from DCF or KHDE-DHCF.

You can easily register to vote using this website: <https://www.kdor.org/voterregistration/>

Or, DCF can help you with the voter registration. Would you like our help in registering to vote?

No Yes Already registered where I live now.

If you do not check any boxes, you will be considered to have decided not to register to vote at this time. This decision will remain confidential and will be used only for voter registration purposes. If you have additional questions or need to report a problem, you may contact your county elections officer, the Secretary of State's office, or call 1-800-262-VOTE(8683). If you do register to vote, information regarding the office where the application was submitted will remain confidential and be used only for voter registration purposes.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose you own political party or other political preference, you may file a complaint with the Kansas Secretary of State.

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 pregnancy, birth of a baby, someone leaving or moving into your house, a new job, change of income, new address, etc.);
- turn alimony and child support payments over to DCF if you receive cash assistance, and cooperate with Child Support Services (CSS) if you receive cash assistance (TANF) or child care assistance;
- pay your child care provider for services;
- use, and report to DCF, 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 assistance only);
- cooperate with Quality Assurance staff if your case is reviewed; and
- look for a job and participate in work related services, starting from the date that you apply for cash assistance.

Your Rights

You have a right to:

- have an interpreter provided at no cost if English is not your primary language;
- have information given to DCF kept confidential, unless directly related to the administration of DCF programs;
- withdraw your application at any time;
- Request a fair hearing within 30 days for cash, child care and medical assistance, or within 90 days for food assistance if you disagree with the decision. For food assistance, you may request a fair hearing verbally or in writing. Your case may be presented by a household member or by a representative such as legal counsel, a relative, a friend or other spokesperson;
- know that if you apply for food assistance benefits, your application for food assistance may not be denied solely because benefits have been denied for other programs;
- have your benefits determined from the date this application is received by DCF;
- special considerations and confidential services, if looking for a job or pursuing child support puts you 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 and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

DCF Rights

DCF 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. For child care assistance only, SSN is voluntary;**
- **verify the alien status of applicant household members by submitting information from the application to USCIS. The information received may affect the household's eligibility and 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 arresting people who are running from the law.**
- **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, child care providers, 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 KDHE - DHCF to administer medical assistance.**

Fraud Penalties

A. Food Assistance - Any member of your household who intentionally breaks the following rules will be disqualified as stated below:

- Do not lie or hide information to get benefits that your household should not get.
- Do not use, or have in your possession, Vision Cards that are not yours.
- Do not trade or sell Vision Cards.

If you make false or misleading statements and you are found guilty of misrepresentation, you will not be able to get food assistance benefits:

- for 10 years if your misrepresentation was about where you live or who you are in order to get duplicate benefits;
- for 1 year if your misrepresentation was about something other than identity or residence and it is your first program violation;
- for 2 years if your misrepresentation was about something other than identity or residence and it is your second program violation;
- ever again if your misrepresentation was about something other than identity or residence and it is your third program violation.

Your food assistance eligibility will also be suspended for 2 years or permanently lost if you are convicted of buying or selling over \$500 worth of benefits or if you use the benefits, or receive them, in a sale of controlled substances, firearms, ammunition or explosives. In all of these cases, the remainder of your food assistance household can get benefits if they are otherwise eligible, but the rest of the household will still be responsible for repaying the amount of any benefits overpayment that was received by the person disqualified.

B. Medicaid - The Kansas Medicaid Fraud Control Act (K.S.A. 2011 Supp. 21-5925 through 21-5934 and K.S.A. 2011 Supp. 75-725 and 75-726) makes it a crime to make a false claim, statement or representation to the Medicaid program, or to trade a Medicaid number for money or other compensation, sign for services that are not received by the Medicaid recipient or sell or exchange for value goods purchased or provided under the Medicaid program. Such crimes could represent a felony offense punished by up to 34 months imprisonment and a fine of up to \$100,000.

Permission to Release Information and Signature

My signature on this application authorizes employers, child care providers, 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 for Children and Families (DCF) and to the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE - DHCF) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program (including Child Support Services) for which I applied.

I authorize DCF and KDHE-DHCF 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 DCF or KHDE-DHCF 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. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person to obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 2011 Supp. 21-5801, which could be a felony offense punished by over 11 years imprisonment and fine of up to a \$300,000.

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

