STATE OF KANSAS
DEPARTMENT FOR CHILDREN AND FAMILIES
ECONOMIC & EMPLOYMENT SERVICES

ES-3100.3
10-04

CERTIFICATION OF NEED FOR TUBERCULOSIS TREATMENT

Name (Last, First, MI):			Contact Person (Guardian, Spouse, Parent, etc):		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone No:	County:		Phone No:		
Facility (if applicable):			Relationship to Individual:		

Date of Birth:		Social Security Number (if applicable):				
Individual's Race	☐ Asian	☐ Black	☐ Hispanic	☐ Native American	☐ White	☐ Other:
Primary Language: Spoken		Written				
Health Insurance Information: Do you have Medicare or other health insurance coverage?						
☐ No	☐ Yes, complete and attach copies of insurance cards:					

Company Name	Type of Coverage (Hospital, Medical, RX, etc.)	Policy/Claim Number

AUTHORIZATION TO RELEASE INFORMATION

My signature on this application authorizes my employers, medical 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 any information, including confidential information, necessary to establish my eligibility for assistance or to administer any program for which I have applied. This release is valid from the date 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.

X_____
Signature of Applicant, Guardian/Conservator, or Durable Power of Attorney — Date

X_____
Signature of Contact Person or Medical Representative — Date

FOR KDHE USE ONLY

Patient Authorized for Treatment:	☐ No	☐ Yes, Describe Treatment:
Effective Date of Treatment:		End Date of Treatment (if available):
Signature of KDHE Official:		Date:

Return Completed Form To:
TB Eligibility Specialist
HealthWave Clearinghouse
P.O. Box 3599
Topeka, KS 66601