

Kansas Benefits Card Request For Alternate Payee

I, the undersigned, request that

(Alternate Payee Name)

Whose mailing address is:

(Street)

(City, State, Zip code)

Be designated as an alternate payee for my:

- Cash Assistance account;*
- Food Assistance account; and/or*
- Child Care account.*

The alternate payee must contact the local DCF office to provide either their SSN or select a password for EBT purposes – the case Primary Individual cannot provide the SSN or password. A password can be used in lieu of their SSN. Passwords can be up to 16 alpha-numeric characters. For EBT account security, alternate payees that have inactivity on the EBT account for 90 days or more will be removed and their EBT card deactivated.

I understand he/she will be issued a Kansas Benefits Card for the above account(s). I understand that this gives the alternate payee unrestricted access to my cash, food assistance, and/or child care benefits and that any funds spent by the alternate payee will not be replaced.

Signature

Date

For Office Use Only	
Case Name: _____	Case Number: _____
Alternate added to: <input type="checkbox"/> KEES	<input type="checkbox"/> ebtEDGE WebAdmin

This form supersedes form ES-3141, 10-14.