STATE OF KANSAS
DEPARTMENTÁØUÜÁÔPŠÖÜÒÞÁŒÞÖÁØŒT ŠÖÒÙ
ECONOMIC & EMPLOYMENT ÙÒÜXÔÒÙ

07-2009
ES-3178

Authorization Form for the Release of Information

I hereby authorize the Nursing Facility listed below to inquire and receive information regarding my application and eligibility for Medicaid with the Kansas Department for Children and Families (DCF). DCF may share with nursing facility listed below any information regarding my Medicaid eligibility status, pending questions regarding my eligibility, and patient obligation amounts.

Nursing Facility: ____

Address: ____

City, State Zip: ____

Telephone Number: ____

I authorize the release of this information to the facility named above for the following period of time:

From: ____ / ____ / _________ To: ____ / ____ / _________

Please retain this Authorization Form for Release of Information in your files for future inquiries from the person named above.

Member/Applicant Information

____ ________________________
Resident's Name (please print) Social Security Number

____
Address

____
Name of Guardian/Conservator or Durable Power of Attorney (please print)

____ ________________________
Signature of Resident, Guardian/Conservator or Durable Power of Attorney Date