ES-3821
03/2015

RENEW YOUR MEDICAL ASSISTANCE COVERAGE NOW!
DON'T LET YOUR COVERAGE END!

Label

It is time to renew your medical assistance coverage. If you want your coverage to continue, you **must** complete the enclosed review form and return it to us no later than _____.

If you do not complete, sign and send the review form to us, your medical assistance coverage will end _____.

The enclosed KC1500 form is for your medical assistance coverage only. You will receive a separate form to complete for any other programs that need to be reviewed.

When you complete the form, remember to:

* Sign and date the form
* Send proof of income and assets
* Send copies of all information needed

Return the completed form to your local DCF office:

_____
_____
_____

WARNING! If you do not return the review form:

* We will stop paying your nursing home, HCBS or other long term care costs
* We will stop paying your Medicare premiums
* Your Social Security check may be reduced by $105 each month
* Your Medicare Part D Extra Help may end

This action is based on the Kansas Economic and Employment Services Manual (KEESM) Section 9300.

Local DCF Office: _____ Signature/Date: _____