State of Kansas
Social and Rehabilitation Services
Economic and Employment Support

# Application/Redetermination
# Medicare Savings Plans

ES 3100.8
01 06

This is an application only for the following types of medical coverage:

Qualified Medicare Beneficiary (QMB)
Low Income Medicare Beneficiary (LMB)
Medicare Part D Subsidy

Estate Recovery does not apply to these programs.

**Agency Use Only**
Date Received: _____
Dated Registered: _____
Case #: _____
Worker: _____

**Instructions:**

- ☐ Complete the whole form. If you need more room to write, attach additional pages.
- ☐ Include copies of documents where requested.
- ☐ Sign the application at the bottom of the last page. Your application is not complete until it is signed.
- ☐ Read your rights and responsibilities on the last page.

## A. Tell us Your Mailing Address:

| Last Name | First Name | MI |
|---|---|---|
| | | |

| Address | Apt. # |
|---|---|
| | |

| City | State | Zip Code |
|---|---|---|
| | | |

| Telephone | E-mail | County |
|---|---|---|
| | | |

## B. Do you appoint someone other than your spouse to manage your medical assistance case with SRS?

☐ No ☐ Yes, complete following:

| Last Name | First Name | Telephone |
|---|---|---|
| | | |

| Address | Apt. # |
|---|---|
| | |

| City | State | Zip | E-mail |
|---|---|---|---|
| | | | |

I appoint this person to be my representative to apply for and manage my medical assistance case.

Signature: _____

## C. Language: Do you prefer a language other than English or need other media to communicate (e.g., Braille?)

☐ No ☐ Yes Spoken: _____ Written: _____

Other Media (Be specific): _____

## D. Personal Information:

| | Last Name | First Name | MI | Date of Birth | Social Security Number | Sex |
|---|---|---|---|---|---|---|
| You | | | | | | |
| Spouse | | | | | | |

## E. Do you or your spouse have other health insurance?

☐ No ☐ Yes, list company and provide copies of the card(s): _____

## F. Household

Do you and your spouse live with other relatives? ☐ No ☐ Yes

If yes, do they rely on you and your spouse for at least one-half of their support? ☐ No ☐ Yes, list relatives and

Relationship to you: _____

## G. Unearned Income

List all sources of income for you and your spouse. Some examples include:

- Social Security
- Veterans Benefits
- Pensions or Retirement
- Rent or Similar Income
- Support or Alimony
- Oil Royalties/Mineral Rights
- Payment from annuities or other investments

List all income.

| ***Please Provide Proof of all Income*** | | **Amount Before Deductions** | **How Often Received** |
|---|---|---|---|
| **Name** | **Type and Source of Income** | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## H. Wages or Self-Employment Income:

1. Do you or your spouse work? ☐ No ☐ Yes, complete the following:

| ***Please Provide Proof of ALL Income*** | | **Amount Before Deductions** | **How Often Received** |
|---|---|---|---|
| **Name** | **Employer Name and Address** | | |
| | | | |
| | | | |

2. Do you have expenses related to your disability that help you stay employed, such as special transportation?

☐ No ☐ Yes, list expenses and amounts: _____

| Are you in a Medicare Drug Plan (Part D)? | | | | Medicare Claim Number | U.S. Citizen N | U.S. Citizen Y | Race Ethnic (codes below) | Applying for Coverage ? N | Applying for Coverage ? Y |
|---|---|---|---|---|---|---|---|---|---|
| | No | | Yes, list plan: | | | | | N | Y |
| | No | | Yes, list plan: | | | | | N | Y |

**FOR RACE/Ethnic:** Use any of these codes that apply. Your coverage will not be affected if you do not answer. (**A**) American Indian/Alaskan native; (**B**) Black; (**H**) Hispanic/Latino; (**P**) Native Hawaiian/ Pacific Islander; (**S**) Asian (**W**) White

## I. RESOURCES: Do you or your spouse have any assets or resources?

| | No | | Yes, list below and ***provide proof***. |
|---|---|---|---|

| Type | Balance/ Value | Where is Asset Held? (Name of Bank, Company, etc.) | Owners | Account No. | Agency Use |
|---|---|---|---|---|---|
| 1 Bank Accounts | $ | | | | |
| | $ | | | | |
| 2 Stocks & Bonds | $ | | | | |
| | $ | | | | |
| 3 Funeral or Burial Plans | $ | | | | |
| | $ | | | | |
| 4 Trust Funds or Annuities | $ | | | | |
| | $ | | | | |
| 5 Motor Vehicles | Year ____ Make ____ Model ____ Owner(s) ____ | | | | |
| | Year ____ Make ____ Model ____ Owner(s) ____ | | | | |

6 Life Insurance - ***Provide copies of all policies***.

| | Policy Owner | Insurance Co. | Policy Number | Face Value |
|---|---|---|---|---|
| a | | | | |
| b | | | | |
| c | | | | |

7 Do you or your spouse own a home? ☐ No ☐ Yes, list value ____

8 Do you or your spouse have any other property or assets? ☐ No ☐ Yes, describe below:

| | Asset/Description | Value |
|---|---|---|
| a | | |
| b | | |
| c | | |

## STATEMENT OF UNDERSTANDING AND AGREEMENT

I understand that disclosure of confidential information is limited to program administration purposes only.

I agree that, upon approval for medical assistance, all rights to past, present, or future support and any rights to payment for medical care on behalf of anyone approved are automatically assigned to Social and Rehabilitation Services (SRS) and the Division of Health Policy and Finance (DHPF).

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility. This may include computer match or other inquiries of the IRS, Social Security Administration, employers, medical providers, financial institutions, and other professional organizations, and government agencies.

I agree to provide documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which SRS and DHPF may obtain the necessary proof.

I understand that my signature authorizes the use of my (our) Social Security Number(s) to administer programs I have applied for.

I understand that I have the responsibility to use and report any third-party resources that may have a legal obligation to pay any or all of my medical expenses. I hereby authorize payments under medical assistance to be made directly to medical providers on any future unpaid bills for health services furnished me while eligible. I understand that payment for a particular service may be withheld until a determination of payment from another source is made.

**I agree to notify of changes in income, resources (including changes in ownership), address, living arrangement and other changes which might affect my assistance within ten (10) days.**

I understand that my application will be considered without regard to race, color, sex, age, handicaps, religion, national origin, or political belief.

I understand that I may request a fair hearing if I disagree with an agency decision on my case and that I may be represented by any person I choose.

I certify that I, or any persons for whom I am applying, am a U.S. citizen or an alien in lawful immigration status.

I understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

## 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 of Social and Rehabilitation Services and the Division of Health Policy and Finance 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 | Signature of Contact Person or Medical Representative | Date |
| Signature of Applicant's Spouse | Date | | |
| Signature of Witness (If Signed by mark) | Date | Signature of Witness (If Signed by mark) | Date |