State of Kansas
Department for Children and Families
Prevention and Protection Services

PPS 5460
REV. Jul-24

KDOC-CBS NOTICE OF CHANGE IN MEDICAID ELIGIBILITY OR CSE STATUS

I. Identifying Information: **County Code:** _____ **DCF Client ID Number (if known)** _____

Youth's Name **Date of Birth:** **SSN:**

II. Placement Change:

Type of Placement:

- ☐ Independent Living
- ☐ Juvenile Correctional Facility*
- ☐ Jail/Detention *
- ☐ Runaway*
- ☐ Parents*
- ☐ All Foster Homes except Relative
- ☐ Relative Home (non parent)
- ☐ YRC I
- ☐ YRC II
- ☐ PRTF
- ☐ Emergency Shelter
- ☐ Kinship/Non- Relative Kinship Care
- ☐ Residential Maternity Care
- ☐ TLP/CIP
- ☐ Others: _____

* Ineligible for Medicaid

Date Placed: _____

Previous Placement Name _____
Address: _____
Address: _____
From: _____ **To:** _____

Current Placement Name: _____
Address: _____
Address: _____
From: _____

Medicaid Card Mailing Address (if different):

- ☐ Send Medicaid card to the current placement address indicated above
- ☐ Send Medicaid card to the following location:

Name: _____
Address: _____
Address: _____
Address: _____

III. Changes in Health Insurance:

- ☐ Policy Terminated effective: _____
- ☐ New or Existing Policy effective (provide details below, attach front and back copies of card.):

HMO / PPO: ☐ Yes ☐ No If HMO / PPO, Name of Primary Care Physician:

Name of Insurance Company:	Insurance Company's Address:
Employer:	

Medical: ☐ Yes ☐ No	Hospital: ☐ Yes ☐ No	Dental: ☐ Yes ☐ No	Policy #:	Group #:

Name of Policy Holder:	Relationship to Youth:

V. Custody:
KDOC Relieved of Custody / Date (Attach court order if available):

VI. Comments:

KDOC-CBS Case Manager Name **Phone Number** **Date**

Distribution: DCF Local Office, CSE Local Office, Juvenile's File

Kansas
Department for Children and Families