A P P L I C A T I O N F O R

1-800-792-4884 **1-800-792-4292 (TTY)**

Help with the Application Process:

In Question 2, if you wish to indicate your race/ethnicity please use the following one letter symbols:

- ***A:*** *Native American or Alaska Native*
- ***B:*** *Black or African American*
- ***H:*** *Hispanic or Latino*
- ***P:*** *Pacific Islander or Native Hawaiian*
- ***S:*** *Asian*
- ***W:*** *White*

In Question 2, if anyone is pregnant, list "unborn child" under the full name box, and also list the names of the unborn child's parents.

In Question 3, you must provide pay stubs for the past three months or an employer statement showing gross wages for the past three months. Be sure and include any other types of income.

In Question 4, you can verify your child care expenses with three months of receipts from your child care provider, or a signed statement from your provider.

In Question 8, complete if you or anyone in the family has been covered by health insurance in the last six months. Also provide a copy of the front and back of the insurance card.

Children may be eligible for coverage if family income falls within the guidelines below. HealthWave coverage for parents requires different income guidelines, and additional factors are used to determine parent eligibility. All eligibility factors, including income guidelines, are subject to change.

Premiums charged to HealthWave XXI families will not exceed 5% of their total family income.

	Yearly	Monthly	Weekly
Family of 1	$18,624	$1,552	$361
Family of 2	24,984	2,082	484
Family of 3	31,344	2,612	607
Family of 4	37,704	3,142	731
Family of 5	44,064	3,672	854
Family of 6	50,424	4,202	977
Family of 7	56,784	4,732	1,100

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For agency use only:

Date Received _____ Date Registered _____

Case Number _____

1. Applicant information: The applicant is usually the person filling out this form. If you are applying for children only, a parent or guardian would be the applicant.

Name of Applicant (include other names used) _____

Home Address _____ Apt. or Lot # _____

City _____ County _____ State _____ Zip Code _____

Mailing Address (if different) _____ City _____ Zip Code _____

If we need additional information, we will try to contact you by phone. Which time is the best to reach you? ***AM*** or ***PM*** (circle one)

Home# (_____) _____ Work#(_____) _____ Message#(_____) _____ Is it ok to call you at work? ***Yes*** or ***No*** (circle one)

2. Tell us about your family: Please list everyone living in your home starting with yourself on the first line. Mark which individuals you are applying for. If pregnant, list "unborn child".

FULL NAME	ARE YOU APPLYING FOR THIS PERSON?		COMPLETE THE FOLLOWING FOR EACH PERSON APPLYING FOR COVERAGE SOCIAL SECURITY NUMBER*	US CITIZEN		HOW IS THIS PERSON RELATED TO YOU?	DATE OF BIRTH	SEX	IF PREGNANT, INDICATE EXPECTED DUE DATE	RACE/ ETHNICITY *OPTIONAL*	FULL NAME OF PARENTS *ONLY FOR CHILDREN UNDER 18*	
	YES	NO		YES	NO						FATHER	MOTHER
						self						

*A social security number is required if coverage is requested for that individual. Providing an SSN for everyone listed may help us serve you better.

3. Tell us about your income: If anyone receives the following types of income, complete the chart below. **Please attach proof of income *(pay stubs or a statement from your employer)* for the past three months.**

Self employment is addressed in Section 5. Please use additional sheet of paper if you need more space.

- employment/tips
- unemployment
- child support
- social security/SSI
- worker's compensation
- monthly income from family
- military allotments
- veteran's benefits
- rental income
- pensions
- alimony
- other (investment income, interest, etc.)

NAME OF PERSON WORKING OR RECEIVING INCOME	TYPE OF INCOME	EMPLOYER NAME AND TELEPHONE NUMBER IF APPLICABLE	AMOUNT RECEIVED BEFORE TAXES/DEDUCTIONS	AMOUNT OF TIPS OR COMMISSION	HOURLY WAGE AND HOURS WORKED PER WEEK	HOW OFTEN PAID? WEEKLY, EVERY TWO WEEKS, TWICE PER MONTH, MONTHLY	DAYS OF WEEK/ MONTH PAID	DATE OF NEXT PAYCHECK

4. Child care expenses: Please provide proof of your child care expenses for the past 3 months for each child. We can accept copies of child care receipts or a statement from your child care provider.

1. NAME OF CHILD	AMOUNT YOU PAY	HOW OFTEN PAID	2. NAME OF CHILD	AMOUNT YOU PAY	HOW OFTEN PAID	3. NAME OF CHILD	AMOUNT YOU PAY	HOW OFTEN PAID	4. NAME OF CHILD	AMOUNT YOU PAY	HOW OFTEN PAID

5. Self Employment: Please list anyone who is self employed and attach a copy of their most recent complete tax return (if filed) or documents showing income and expenses for the past three months.

NAME	NAME AND TYPE OF BUSINESS	HOURS WORKED PER WEEK	TOTAL MONTHLY INCOME BEFORE EXPENSES ARE DEDUCTED	TOTAL MONTHLY EXPENSES

6. Unpaid Medical Bills: We may be able to cover unpaid health care expenses from the past three months. If anyone you are applying for has unpaid medical expenses from the past three months, and you would like us to find out if you qualify for this program circle ***Yes*** or ***No***. You must include proof of income for the past three months.

7. Trust Funds: Does anyone you are applying for have a trust fund? ***Yes*** or ***No*** (circle one). If yes, we will contact you for more information.

8. Health Insurance: Tell us about anyone listed on page 1 – who is covered or who has been covered in the past six months by health insurance of any kind.

LIST THE NAME OR NAMES OF PERSONS COVERED			
	1	3	5
	2	4	6

Insurance company _____ Type of coverage _____
Please provide a copy of the front and back of their insurance card. *health, accident, major medical, dental, or other*

Start Date_____ End Date_____ If health insurance has ended for anyone in the past six months, please explain why _____

_____

9. What primary language do you speak at home? (optional) *English ____ Spanish ____ German ____ Hmong ____ Vietnamese ____ French ____ Italian ____ Other _____*

10. Important Conditions and Authorization to Release Information:

I understand I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin.

I understand I have the right to have information I have provided kept confidential unless directly related to the administration of HealthWave, HealthConnect, or other benefit programs.

I understand that I have to provide or apply for a social security number for anyone who is applying for health benefits and I authorize use of these numbers to administer the program. These numbers will also be used for computer matches with other organizations such as banks, the social security administration and internal revenue service.

I certify that everyone I am requesting health coverage for and who is determined eligible for such coverage is a U.S. citizen or is a non-U.S. citizen in lawful immigration status.

For anyone you are requesting coverage for, proof of immigration status may need to be provided.

I understand it is important to provide current income, address and household composition information.

I understand I have the responsibility to use and report any third party resources (such as health insurance, court settlements, medical support payments, trusts, conservatorships, etc.) that may have a legal obligation to pay any or all of the medical expenses of those for whom I am applying. I understand that payment for a particular service may be withheld while a determination of failure to use a third party resource is made.

I understand that some or all of the people for whom I am applying may receive similar health coverage under the Medicaid program if eligible.

I authorize payments under this program to be made directly to physicians and other medical providers on any medical and other health services furnished to those for whom I am applying while eligible.

I understand the questions on this application and I understand there are penalties for hiding information or giving false information.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.

If applying for adults and children and if any of those adults are determined eligible for medical coverage, I agree to help child support enforcement (CSE) in establishing and enforcing support orders (if needed). If the adults in the household are eligible for medical assistance, I agree to turn over any medical support payments for all persons receiving medical assistance.

I understand that any payments made to me by a third party resource for medical services covered under the HealthWave and HealthConnect programs will be used to pay for the applicable medical bills and that these programs will only pay for services not covered by that third party resource. I agree to cooperate with the medical subrogation unit in pursuing those third party resources.

I authorize medical providers under this program to release medical information to the Department of SRS, the U.S. Department of Health & Human Services, insurance companies and other contracted medical providers. I also authorize SRS to share medical information for administrative purposes with other agencies and contractors. This is an application for HealthWave and HealthConnect only. You may apply for other medical programs, such as elderly and disabled programs, at your local SRS Office.

I understand I have the right to request a fair hearing if I disagree with a decision. A written request must be made within 30 days of the decision.

11. Signature: This application must be signed and dated in order to be considered a complete application.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF SPOUSE OR OTHER ADULT (IF APPLYING) _____ DATE _____

My signature on this application signifies that I have read and understand the conditions above. It also authorizes employers, medical providers, financial institutions, insurance providers, benefit providers and other persons or agencies with knowledge of my circumstances to release to HealthWave, HealthConnect, or other benefit programs any information, including confidential information, necessary to establish my eligibility. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from this date. A copy of this authorization is as valid as the original.

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APPLICATION FOR

health wave
moving forward with health care for kansans

HEALTHCONNECT Kansas

IMPORTANT
Things to Remember

Carefully read and answer all questions on the enclosed application (if there is not enough room on the application use additional sheets of paper).

Include copies of all supporting documents with the application (do not send originals).

If you are 18 years old you should fill out a separate application.

Be sure to sign and date the application, expect to hear something in 6-8 weeks.

Use the enclosed postage paid envelope to mail the application and copies of supporting documents.

To obtain an application in another language, free interpreter services, or free general application assistance, call 1-800-792-4884 or 1-800-792-4292 (TTY).

All applications will be screened for Medicaid first.

If you are 18 or older and choose HealthConnect, some medical services will have a co-pay ranging from $1.00 to $3.00.