KANCARE: GROSS MONTHLY INCOME STANDARDS (INCOME BEFORE TAX)

Number of Persons Included in household	KanCare under the Medicaid plan **Pregnant Women and Children Under 19**			KanCare under the CHIP plan **Children Under 19**
	113% of federal poverty level (ages 6 thru 18)	149% of federal poverty level (ages 1 thru 5)	171% of federal poverty level (pregnant women & ages under 1)	225% of federal poverty level (ages 0 thru 19 & income exceeds Medicaid)
1	$1,177	$1,551	$1,780	$2,446
2	$1,593	$2,100	$2,410	$3,312
3	$2,009	$2,649	$3,040	$4,178
4	$2,425	$3,198	$3,670	$5,043
5	$2,842	$3,747	$4,300	$5,909
6	$3,258	$4,295	$4,930	$6,774

KDHE Fact Sheet 9, April 2019

IMPORTANT NOTES

KEEP A COPY OF EVERYTHING YOU SEND. Write down the date and time you sent it, then call the Clearinghouse to check they received it. Write down the representative's name and date/time the call took place. Do this for the application itself (and renewals) and each time you have to send an additional document. When confirming a receipt, ask if they would recommend sending any other additional document.

Write down your case number: _____

Include it at the top of each page for additional documents you may have to send.

APPLICATION CHECKLIST

Sent? Date KanCare received it Rep's Name & Date

☐ **Application** _____ _____

If doing it online, screenshot the pages & confirmation number.

☐ **Proof of income** _____ _____

Provide at least the last 30 days of income. If unemployed, write a letter stating so if you do not have an official document.

☐ **Proof of health insurance** _____ _____

If you or your child do not have health insurance, write a letter stating so.

☐ **Proof of representation** _____ _____

If you are not the biological parent, provide the placement agreement or other legal document stating you are responsible for the child.

FOR FAMILIES WITH CHILDREN UNDER 18 YEARS OR EXPECTING PARENTS, PLEASE CALL COTTONWOOD PEDIATRICS FOR FREE ASSISTANCE WITH THE APPLICATION PROCESS.

cottonwoodpeds.com | 700 Medical Ctr Dr, Ste 150 - Newton, KS | P:(316)283-7100

Cottonwood Pediatrics

Kansas Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
Fax: 844-264-6285

KanCare

Facilitator Authorization Form

Consumer Name: _____

Consumer ID or SSN: _____

You can name a person to help you with your medical assistance case. This form is used to appoint a Facilitator.

A Facilitator is a person or organization who can help you fill out your application and help you through the application process. You remain in charge of your case. We will be able to share information with this person. They will get copies of letters sent to you about your application. You have the option to tell us how long you want the information to be shared (see below). This release will stay in effect until your application is completed. A facilitator can be a relative, neighbor, friend, medical office staff, or community organization employee.

They cannot make requests for coverage for you.

First and Last Name	Aline Bandeira				
Organization Name	Cottonwood Pediatrics				
Address Line 1	700 Medical Center Dr, Ste 150				
Address Line 2					
City	Newton	State	Kansas	Zip Code	67114
Phone Number	316-283-7100	Email Address	office@cottonwoodpeds.com		
What is this person's relationship to you? (for example: child, friend, neighbor, medical provider, community organization, etc.)			Medical provider staff		

I authorize the use or disclosure of my health information by the person named above to KDHE DHCF, DCF, and KDADS.
I understand that I have the right to revoke this authorization at any time by notifying KDHE DHCF.
I understand after this information is disclosed to a third party Federal law might not protect the information.
I understand that I am entitled to a copy of this authorization.
I understand that this authorization will expire 12 months from the date this form is signed or once my application is completed, whichever is later. Or you may provide a different date for the expiration of this release: _____.

My signature on this form signifies that I have read and understand the conditions above.

Signature: _____ Date: _____