If you need assistance completing the application, please contact kansmilefoundation@gmail.com.

To speed the application process please complete the entire application and include the following information:

To determine financial eligibility, we will need copies of the sources of income received by all household members who are financially responsible for applicant. Please send the following:

- ☐ Six (6) most recent pay stubs/checks, *OR* three (3) months of paystubs, if paid monthly. (If you have been with your employer for more than 3 months, paystubs are required)
- ☐ If you have been with your employer for less than 3 months, a statement of likely earnings is required on company letterhead, signed and dated by employer with employer's contact information.
- ☐ Profit/Loss statement for the last three (3) months **(Self-Employed ONLY)**

Include client's name in all documentation submitted.

Failure to complete any part of the application or consent form will result in the application or forms being sent back to you for completion. This will delay the application process until the fully completed form is returned.

FAMILY'S RESPONSIBILITIES-I HEARBY AGREE TO:

If uninsured, applicant must apply for Medicaid, if applicable.

Repay KanSmile, any insurance proceeds sent directly to me, if the insurance payment is made for treatment or equipment provided.

I also agree to notify KanSmile within 30 days of the following:

The applicant becomes eligible for Medicaid, Supplemental Security Income, Disability Payments, and TANF Payments or Changes in the applicant's address, income, marital status, custody of children, family income or cash assets of $500 per year or other circumstances that affect the applicant or eligible person.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 2011 Supp. 21-5801, which could be a felony offense.

____

Signature of Parent, legal guardian, applicant if over age 18 or authorized representative

____

Relationship to Applicant

____

Date

KANSMILE APPLICATION
DEMOGRAPHIC INFORMATION

Applicant's Name: _______________________________Birth Date:________________

Sex: ☐ Male ☐ Female **Social Security # (Optional) ___________________**

Email Address______________________________

Applicant or Parent Phone Number (___)________________

Applicant's Diagnosis ______________________________________

Home Address: ______________________________ **Apt. # ______**

City: ______________ State: _____________ Zip: _______ **County: _____________**

Do you speak English? ☐ Yes ☐ No **If No, language spoken: ___________________**

Contact Person Who Speaks English: __________________ Phone #: (___)_____________

Are you or your child a client of the Special Healthcare Needs Program through the Kansas Department of Health and Enviroment? ____

Do you or your child receive assistance coordinating care from another agency/organization? ____

If yes, what other agency/organization are you receiving from? ________________

What type of assistance do they provide you with? ________________________________

Race:

**The answer will not affect eligibility. The answer will be used to collect information about people who apply for the program.*

- ☐ American Indian
- ☐ Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Other________________________________

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Spanish/Hispanic/Latino
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic or Latino
- ☐ Hispanic
- ☐ Other________________________________

KANSMILE APPLICATION
PARENT/GUARDIAN INFORMATION

Applicant's Name: ____________________________ Birth Date: ___________________

Parent/Applicants Marital Status:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Parent(s) and Phone Number (where child lives) (Check to indicate step-parent)
Last First MI Phone Number

____(___)________ ☐

____(___)________ ☐

Name of Legal Guardian if Different from Parents: _______________________

Phone Number: (___)_____________

Home Address: _________________________________ Apt. # ______

City: _______________________ State: ______________ Zip: ________

____

KANSMILE APPLICATION
FINANCIAL INFORMATION

Applicant's Name: ______________________________ Birth Date: ____________________

List ALL the income received by people living in your household (related & non-related). Be sure to include all sources of gross income (before taxes) such as wages, dividends and interest, assistance from DCF (TANF, food stamps), SSI, annuities, pensions, disability, child support, alimony, unemployment and other unearned income.

Name	Employer Name	Work / Phone #	Gross Amount	How Often
			$	☐ Weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
			$	☐ Weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
			$	☐ Weekly ☐ every 2 weeks ☐ twice a month ☐ monthly

	Amount	How Often
Food Stamps:	$___________	___________
SSI Income:	$___________	___________
SSDI Income:	$___________	___________
Child Support:	$___________	___________

List all the cash assets for all people living in your household (include cash, checking/savings accounts, certificates of deposit, stocks & bonds) excluding 401(k) and retirement.

Type of Resources	Primary Account	Value
		$
		$

Applied for Medicaid/ KanCare Yes / No	Name of Insurance Company	Start Date	Policy & Group Number	Deductible per Individual	Dental Orthodontic Coverage Yes / No	Receiving SSI Yes / No

KANSMILE APPLICATION
CONSENT FOR RELEASE OF INFORMATION

Applicant's Name: ______________________ **Birth Date:** __________

Home Address: ______________________ **Apt. #:** __________

City: ______________________ **State:** ______ **County:** __________

I hereby authorize KanSmile to obtain medical information to and from the following (Checking the boxes affirms consent). Please include contact information.

- ☐ Hospital ______________________
- ☐ Physician ______________________
- ☐ Parents As Teachers ______________________
- ☐ Medicaid/KanCare ______________________
- ☐ School District # ______________________
- ☐ Private Insurance ______________________
- ☐ Case Worker ______________________
- ☐ CDDO ______________________
- ☐ Childcare Provider ______________________
- ☐ Early Head Start/Head Start ______________________
- ☐ Kansas Department for Children and Families
- ☐ TRICARE ______________________
- ☐ Other ______________________
- ☐ Other ______________________
- ☐ Other ______________________
- ☐ Other ______________________

Expiration: This authorization shall expire one year from the date signed.
Purpose: Medical eligibility determination, care coordination, quality assurance of treatment services.
Statements of Understanding:

- I understand the potential for KanSmile to re-disclose this information and may no longer be protected by federal law.
- I understand that I may revoke this authorization at any time.
- If I revoke this authorization, it will have no effect on actions already taken in reliance of this form.
- I authorize the use or disclosure of the records/information described.
- I have read and understand this form. I have received a copy of this form.
- I am the patient listed or I am authorized to "act on behalf of the applicant/patient as the applicant's personal representative.

______________________ ______________

Parent/Guardian Signature, if applicant is over 18 **Date**

IF OVER 18: I authorize KanSmile to discuss my financial and medical information with the following individuals:

______________________ ______________

Name **Relationship to Applicant**

______________________ ______________

Name **Relationship to Applicant**