

## November 20, 2014 MAC Binder Section 1 – Letters from CMS Table of Contents

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- CMS Letter to DMS regarding KY NEMT Waiver dated Oct. 31, 2014

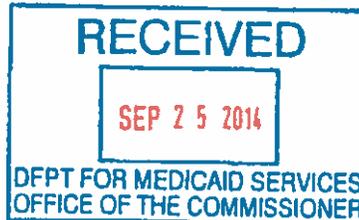
DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, GA 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

September 19, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001



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MAC

FBI  
9/25/14

Dear Mr. Kissner:

On November 6, 2013, the Centers for Medicare & Medicaid Services (CMS) approved Kentucky's State Plan Amendment (SPA) 13-0007-MM2 with an effective date of January 1, 2014. This SPA included approval for the state to use interim alternative single streamlined online and paper applications until June 30, 2014.

The CMS has reviewed the changes submitted with respect to Kentucky's alternative single streamlined online and paper applications. The revised applications address the concerns outlined in the companion letter that was issued with the SPA's approval. This letter serves as official approval of Kentucky's alternative single streamlined online application and alternative single streamlined paper application.

Enclosed is a copy of the approved application materials. Please incorporate these pages into the State Plan following the attachments to S94 entitled, "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact Melanie Benning at 404-562-7414 or [Melanie.Benning@cms.hhs.gov](mailto:Melanie.Benning@cms.hhs.gov).

Sincerely,

Jackie Glaze  
Associate Regional Administrator

Enclosure



# Health Coverage & Help Paying Costs

## Application for More Than One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for
Who is this application for?
Apply faster online
What you may need to apply
Why do we ask for this information?
What happens next?
To get help

- Free or low-cost coverage from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP)
- Payment Assistance that can help you pay for your health coverage
- Affordable health insurance plans that offer comprehensive coverage to help you stay well

Members of a household (spouses, partners, children, other) who:

- Live in Kentucky and plan to stay in Kentucky
- Are included on your tax return, even if they don't live with you
- Live with you, even if taxes are not filed

Apply faster online at [www.kynect.ky.gov](http://www.kynect.ky.gov).

- Your social security number (or document number if you are a legal immigrant)
- Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)

We ask about your Social Security Number (SSN), your income and other information to see if you qualify for, and if you can get any help paying for your health coverage costs.

If you need help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call 1-800-325-0778.

We'll keep all the information you give us private, as required by law.

- Mail or fax your completed, signed application to:

**Office of the Kentucky Health Benefit Exchange**  
 12 Mill Creek Park  
 Frankfort, KY 40601

**Fax: 1-502-573-2005**

- If you do not have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us.
- If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.

- Online: [www.kynect.ky.gov](http://www.kynect.ky.gov)
- By phone: Call Customer Service at 1-855-4kynect (459-6328)
- In person: Find a list of places near where you live by visiting our website or calling us.
- Contact an insurance agent or kynector: Visit our website or call 1-855-4kynect (459-6328) for a list of insurance agents and kynectors near you.
- Español: Llame a nuestro Servicio al Cliente gratis al 1-855-4kynect (459-6328)
- TTY users call 1-855-326-4654



# Health Coverage & Help Paying Costs

## Application for More Than One Person

### STEP 1 Tell Us about Yourself (the Responsible Party)

Complete this part of the application with information about the Responsible Party (even if the Responsible Party is not applying for coverage). If you are completing this application for someone else, you must use Appendix B to enter your contact information.

1. First name, Middle initial, Last name & Suffix (as it appears on your Social Security card)

2. Social Security Number (SSN) **We need your SSN if you want coverage and have a SSN. Giving us your SSN can be helpful if you don't want health coverage too since it can speed up the application process.**

3. If you want coverage and SSN is not provided, select the reason for not providing it.  
 Religious Objection       Not eligible to receive SSN due to alien status       Applied for SSN  
 Do not have an SSN and may only be issued an SSN for a valid non-work reason       Refuse to provide SSN

4. If you are applying for health coverage, check here  and answer all questions.  
 If you are **not** applying for health coverage, do not answer questions 25-31 on the next page.

5. Date of Birth (mm/dd/yyyy)      6. Gender  
 Male     Female

7. Do you live in Kentucky and plan to stay in Kentucky? (Only required if you want coverage)     Yes     No

8. Home Address -  Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.

9. City      10. State      11. Zip Code      12. County

13. Mailing Address (Only required if different from home address)

14. City      15. State      16. Zip Code      17. County

18. Primary Phone Number  Home     Work     Cell  
 (      )

19. Secondary Phone Number  Home     Work     Cell  
 (      )

20.  Check here to allow kynect to send text message alerts to your primary phone number.

21.  Check here to allow kynect to send text message alerts to your secondary phone number.

22. Preferred Spoken Language (if not English)

23. Preferred Written Language (if not English)



If you need help with your application or to apply faster online, go to [www.kynect.kv.gov](http://www.kynect.kv.gov) or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110      Rev 06-01-14

24. Do you, the Responsible Party, plan to file a federal income tax return for coverage year 2014?  
(You can apply for health insurance even if you don't file a federal income tax return.)

- YES. If yes, answer questions a-d.  NO. If no, skip to question d.
- a. What will be your filing status?  Married Filing Jointly  Married Filing Separately  
 Single  Head of Household
- b. If married, what is your spouse's name? \_\_\_\_\_
- c. Do you have any tax dependents?  Yes  No  
If yes, list name(s) of dependent(s): \_\_\_\_\_
- d. Are you claimed as a dependent on someone else's tax return?  Yes  No  
If yes, list the name of the tax filer: \_\_\_\_\_  
How are you related to the tax filer? \_\_\_\_\_

Answer the following questions only if you want coverage:

25. Are you offered health coverage from a job (including someone else's job, like a spouse's job)?  
 Yes. If yes, you will need to complete and include Appendix A with this application.  No

26. Do you want help paying for medical bills from the last 3 months?  Yes  No  
If yes, which month(s)? \_\_\_\_\_

27. Are you a U.S. citizen or national?

Yes  No

28. If you are not a U.S. citizen or national, do you have immigration status?

Yes. Answer questions a-d below.

- a. Immigration Document Type: \_\_\_\_\_  
b. Document ID Number: \_\_\_\_\_  
c. Have you lived in the U.S. since 1996?  Yes  No  
d. Are you a veteran or active-duty member of the U.S. military?  Yes  No

29. Are you of Hispanic, Latino or Spanish origin? (OPTIONAL)  Yes  No

30. Race - (OPTIONAL)

- White  American Indian  Filipino  Vietnamese  Guamanian or Chamorro  
 Black or African American  Alaska Native  Japanese  Other Asian  Samoan  
 Chinese  Asian Indian  Korean  Native Hawaiian  Other Pacific Islander

31. If you have lost a household member recently, you may be able to get help paying for his/her medical bills. Please give us the following information about the deceased family member:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender  Male  
Is this person of Hispanic, Latino or Spanish origin? (OPTIONAL)  Yes  No  Female  
Race (OPTIONAL): \_\_\_\_\_

## STEP 2 Other Members of the Household

Next, you will need to give us information about the other members of your household (include all members of your household, even if they do not want health coverage). Include spouse, children, and others who live in Kentucky and plan to stay in Kentucky, are included on your tax return (even if they don't live with you), and live in your household even if taxes are not filed. If you need to include more than four persons on this application, attach additional pages with their information.

Get started with the members of your tax household.



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# Person 2

1. First name, Middle initial, Last name & Suffix (as it appears on Social Security card) \_\_\_\_\_ 2. Relationship to you \_\_\_\_\_

3. Social Security Number (SSN) \_\_\_\_\_ **We need PERSON 2's SSN if PERSON 2 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.**

4. If PERSON 2 wants coverage and SSN is not provided, select reason for not providing it.  
 Religious Objection    Not eligible to receive SSN due to alien status    Applied for SSN    Newborn without SSN  
 Do not have an SSN and may only be issued an SSN for a valid non-work reason    Refuse to provide SSN

5. If PERSON 2 is applying for health coverage, check here  and answer all questions. If PERSON 2 is not applying for health coverage, do not answer questions 12-17.

6. Date of Birth (mm/dd/yyyy) \_\_\_\_\_ 7. Gender \_\_\_\_\_  
 Male    Female

8. Does PERSON 2 live at the same address as the RESPONSIBLE PARTY?  
 Yes. If yes, do not enter an address below.    No. If no, enter PERSON 2's address below.

9. Home Address \_\_\_\_\_ 10. Mailing Address (Required if different from Home Address) \_\_\_\_\_

11. Does PERSON 2 plan to file a federal income tax return for coverage year 2014?  
(Individuals can apply for health insurance even if they don't file a federal income tax return.)  
 YES. If yes, answer questions a-d.    NO. If no, skip to question d.

a. What will be PERSON 2's filing status?    Married Filing Jointly    Married Filing Separately  
 Single    Head of Household

b. If married, what is the spouse's name? \_\_\_\_\_

c. Does PERSON 2 have any tax dependents?    Yes    No  
If yes, list name(s) of dependent(s): \_\_\_\_\_

d. Is PERSON 2 claimed as a dependent on someone else's tax return?    Yes    No  
If yes, please list the name of the tax filer: \_\_\_\_\_  
How is PERSON 2 related to the tax filer? \_\_\_\_\_

12. Is PERSON 2 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)?  
 Yes. If yes, you will need to complete and include Appendix A with this application.    No

13. Does PERSON 2 want help paying for medical bills from the last 3 months?    Yes    No  
If yes, which month(s)? \_\_\_\_\_

14. Is PERSON 2 a U.S. citizen or national?  
 Yes    No

15. If not a U.S. citizen or national, does PERSON 2 have immigration status?  
 Yes. Answer questions a-d below.  
a. Immigration Document Type: \_\_\_\_\_  
b. Document ID Number: \_\_\_\_\_  
c. Has PERSON 2 lived in the U.S. since 1996?    Yes    No  
d. Is PERSON 2 a veteran or active-duty member of the U.S. military?    Yes    No

16. Is PERSON 2 of Hispanic, Latino or Spanish origin? (OPTIONAL)    Yes    No

17. Race - (OPTIONAL)  
 White    American Indian    Filipino    Vietnamese    Guamanian or Chamorro  
 Black or African American    Alaska Native    Japanese    Other Asian    Samoan  
 Chinese    Asian Indian    Korean    Native Hawaiian    Other Pacific Islander



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# Person 4

1. First name, Middle initial, Last name & Suffix (as it appears on Social Security card) \_\_\_\_\_ 2. Relationship to you \_\_\_\_\_

3. Social Security Number (SSN) \_\_\_\_\_ **We need PERSON 4's SSN if PERSON 4 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.**

4. If PERSON 4 wants coverage and SSN is not provided, select reason for not providing it.  
 Religious Objection     Not eligible to receive SSN due to alien status     Applied for SSN     Newborn without SSN  
 Do not have an SSN and may only be issued an SSN for a valid non-work reason     Refuse to provide SSN

5. If PERSON 4 is applying for health coverage, check here  and answer all questions. If PERSON 4 is not applying for health coverage, do not answer questions 12-17.

6. Date of Birth (mm/dd/yyyy) \_\_\_\_\_ 7. Gender  
 Male     Female

8. Does PERSON 4 live at the same address as the RESPONSIBLE PARTY?  
 Yes. If yes, do not enter an address below.     No. If no, enter PERSON 4's address below.

9. Home Address \_\_\_\_\_ 10. Mailing Address (Required if different from Home Address) \_\_\_\_\_

11. Does PERSON 4 plan to file a federal income tax return for coverage year 2014?  
*(Individuals can apply for health insurance even if they don't file a federal income tax return.)*  
 YES. If yes, answer questions a-d.     NO. If no, skip to question d.

a. What will be Person 4's filing status?     Married Filing Jointly     Married Filing Separately  
 Single     Head of Household

b. If married, what is the spouse's name? \_\_\_\_\_

c. Does PERSON 4 have any tax dependents?     Yes     No  
 If yes, list name(s) of dependent(s): \_\_\_\_\_

d. Is PERSON 4 claimed as a dependent on someone else's tax return?     Yes     No  
 If yes, please list the name of the tax filer: \_\_\_\_\_  
 How is PERSON 4 related to the tax filer? \_\_\_\_\_

12. Is PERSON 4 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)?  
 Yes. If yes, you will need to complete and include Appendix A with this application.     No

13. Does PERSON 4 want help paying for medical bills from the last 3 months?     Yes     No  
 If yes, which month(s)? \_\_\_\_\_

14. Is PERSON 4 a U.S. citizen or national?  
 Yes     No

15. If not a U.S. citizen or national, does PERSON 4 have immigration status?  
 Yes. Answer questions a-d below.  
 a. Immigration Document Type: \_\_\_\_\_  
 b. Document ID Number: \_\_\_\_\_  
 c. Has PERSON 4 lived in the U.S. since 1996?     Yes     No  
 d. Is PERSON 4 a veteran or active-duty member of the U.S. military?     Yes     No

16. Is PERSON 4 of Hispanic, Latino or Spanish origin? (OPTIONAL)     Yes     No

17. Race - (OPTIONAL)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian	<input checked="" type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Alaska Native	<input checked="" type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Asian Indian	<input checked="" type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander



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### STEP 3

## Additional Questions

If the answer to the following questions is yes for more than one person, use additional sheets of paper to give us the details.

1. Is anyone that is applying for health coverage on this application currently in prison or jail or has been released in the past three months?

YES. If yes, answer questions a–d.  NO. If no, go to question 2.

a. Who? \_\_\_\_\_

b. When did this person enter prison? (mm/dd/yyyy) \_\_\_\_\_

c. When did this person leave prison? (mm/dd/yyyy) \_\_\_\_\_

d. Is this person currently waiting for a decision on charges?  Yes  No

2. Has anyone on this application had a pregnancy end (giving birth or losing a pregnancy) in the past three months or is currently pregnant?

YES. If yes, answer questions a–d.  NO. If no, go to question 3.

a. Who? \_\_\_\_\_

b. What is the due date or the last date of pregnancy? (mm/dd/yyyy) \_\_\_\_\_

c. How many children are/were expected with this pregnancy? \_\_\_\_\_

d. Would this person like to be referred to WIC (a program that offers food to women, infants & children)?  Yes  No

3. Is anyone on this application American Indian or Alaska Native?

YES. If yes, complete Appendix C and mail it with this application.  NO. If no, go to question 4.

4. Does anyone applying for health coverage on this application need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

YES. If yes, who? \_\_\_\_\_  NO. If no, go to question 5.

5. Is anyone that is applying for coverage on this application blind or permanently disabled?

YES. If yes, who? \_\_\_\_\_  NO. If no, go to question 6.

6. Does anyone in your household that is applying for health coverage on this application currently have other

YES. If yes, answer questions a–h.  NO. If no, go to question 7.

a. Who? \_\_\_\_\_ f. Policy number \_\_\_\_\_

b. Type of coverage \_\_\_\_\_ g. Coverage start date \_\_\_\_\_

c. Name of policy holder \_\_\_\_\_ h. Coverage end date \_\_\_\_\_

d. Name of insurance company \_\_\_\_\_

e. Address of insurance company \_\_\_\_\_

7. Was anyone in your household receiving Medicaid when he/she became too old to be eligible for foster care placement?  YES. If yes, who? \_\_\_\_\_

In what state did he/she live? \_\_\_\_\_ How old was he/she? \_\_\_\_\_

NO. If no, go to Step 4 on next page.



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# STEP 4 Income and Deductions

Use additional sheets of paper if you need to add more than two jobs.

**Income from Job 1**

1. Who earns this income? \_\_\_\_\_

2. Who is this person's employer? \_\_\_\_\_

3. What is the gross amount this person makes (before taxes)?  
\$ \_\_\_\_\_

4. How often?  Weekly  Twice a month  
 Every two weeks  Monthly

5. IF SELF-EMPLOYED

a. Type of work \_\_\_\_\_

b. Gross Income \_\_\_\_\_

c. Self-employment Expenses \_\_\_\_\_

d. NET income (Gross minus expenses) \_\_\_\_\_

e. How often? \_\_\_\_\_

**Income from Job 2**

6. Who earns this income? \_\_\_\_\_

7. Who is this person's employer? \_\_\_\_\_

8. What is the gross amount this person makes (before taxes)?  
\$ \_\_\_\_\_

9. How often?  Weekly  Twice a month  
 Every two weeks  Monthly

10. IF SELF-EMPLOYED

a. Type of work \_\_\_\_\_

b. Gross Income \_\_\_\_\_

c. Self-employment Expenses \_\_\_\_\_

d. NET income (Gross minus expenses) \_\_\_\_\_

e. How often? \_\_\_\_\_

11. **Additional Income:** Give us information about any additional income that household members on this application may receive. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. If none, leave blank.

Type of Income	Who Receives it?	How Much?	How Often?		
<input type="checkbox"/> Social Security	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Pensions	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Interest or Dividend	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Disability Payments	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Unemployment	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other _____	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

12. **Household Deductions:** Give us information about things that members of your household pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower. If none, leave blank.

Type of Deduction	Who?	How much?	How often?		
<input type="checkbox"/> Alimony Paid	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Student Loan Interest	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Educator Expenses	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> School Tuition & Fees	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

13. **Yearly Household Income:** What is your estimated yearly household income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?  
\$ \_\_\_\_\_



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Kentucky

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S94-8

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## STEP 5 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal and/or state law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit [kynect.ky.gov](http://kynect.ky.gov) or call 1-855-4kynect (459-6328) to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

**Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (select one)

- 5 years (maximum allowed)    4 years    3 years    2 years    1 year  
 Do not use information from tax returns or other data sources to renew my coverage.

**Voter Registration:** If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

- Yes, I want to apply to register to vote. An application will be mailed to me.    No, I don't want to register to vote.

**If anyone on this application is eligible for Medicaid or KCHIP:**

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.
- Does any child on this application have a parent living outside of the home?    Yes    No
- If yes, I give the Cabinet for Health and Family Services (CHFS), Child Support Office, the right to enforce medical support from the child's absent parent(s). If I think that cooperating with the Child Support Office will harm me or my children, I can tell CHFS and I may not have to cooperate.

Signature

Date (mm/dd/yyyy)



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Kentucky's Healthcare Connection

# Health Coverage & Help Paying Costs Application for One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for.	<ul style="list-style-type: none"> <li>• Free or low-cost insurance from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP)</li> <li>• Payment Assistance that can help you pay for your health coverage</li> <li>• Affordable health insurance plans that offer comprehensive coverage to help you stay well</li> </ul>
Who is this application for?	<p>Single individuals who:</p> <ul style="list-style-type: none"> <li>• Live in Kentucky and plan to stay in Kentucky</li> <li>• Do not have any dependents and cannot be claimed as a dependent on someone else's tax return</li> </ul>
Apply faster online	Apply faster online at <a href="http://www.kynect.ky.gov">www.kynect.ky.gov</a> .
What you may need to apply	<ul style="list-style-type: none"> <li>• Your social security number (or document number if you are a legal immigrant)</li> <li>• Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)</li> </ul>
Why do we ask for this information?	<p>We ask about your Social Security Number (SSN), your income and other information to see if you qualify for and if you can get any help paying for your health coverage costs.</p> <p>If you need help getting an SSN, call 1-800-772-1213 or visit <a href="http://socialsecurity.gov">socialsecurity.gov</a>. TTY users should call 1-800-325-0778.</p> <p>We'll keep all the information you give us private, as required by law.</p>
What happens next?	<ul style="list-style-type: none"> <li>• Mail or fax your completed, signed application to:           <p style="text-align: center;"><b>Office of the Kentucky Health Benefit Exchange</b> 12 Mill Creek Park Frankfort, KY 40601</p> <p style="text-align: center;">Fax: 1-502-573-2005</p> </li> <li>• If you don't have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us.</li> <li>• If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.</li> </ul>
To get help	<ul style="list-style-type: none"> <li>• Online: <a href="http://www.kynect.ky.gov">www.kynect.ky.gov</a></li> <li>• By phone: Call Customer Service at 1-855- 4kynect (459-6328)</li> <li>• In person: Find a list of places near where you live by visiting our website or calling us.</li> <li>• En Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328)</li> <li>• For TTY services call 1-855-328-4654</li> </ul>



Kentucky's Healthcare Connection

# Health Coverage & Help Paying Costs Application for One Person

## STEP 1

### Tell Us about Yourself

If someone else is helping you fill out this application, use Appendix B to give us that person's information.)

1. First Name, Middle initial, Last name, Suffix (as it appears on your Social Security card)

2. Social Security Number (SSN) **We need your SSN if you want coverage and have a SSN. We use SSNs to check income and other information to see if you are eligible for help with health coverage costs.**

3. If you want coverage and SSN is not provided, select reason for not providing it.  
 Religious Objection       Not eligible to receive SSN due to alien status       Applied for SSN  
 Does not have an SSN and may only be issued an SSN for a valid non-work reason       Refuse to provide SSN

4. Date of Birth (mm/dd/yyyy)      5. Gender  
 Male    Female

6. Do you live in Kentucky and plan to stay in Kentucky?    Yes    No

7. Home Address -  Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.

8. City      9. State      10. Zip Code      11. County

12. Mailing Address (Only required if different from home address)

13. City      14. State      15. Zip Code      16. County

17. Primary Phone Number    Home    Work    Cell      18. Secondary Phone Number    Home    Work    Cell  
(   )      (   )

19.  Check here to allow kynect to send text message alerts to your primary phone number.      20.  Check here to allow kynect to send text message alerts to you secondary phone number.

21. Preferred Spoken Language (if not English)      22. Preferred Written Language (if not English)

23. Have you had a pregnancy end (giving birth or losing a pregnancy) in the past three months or are you currently pregnant?    Yes. If yes, answer questions a-c.    No  
a. What is the due date or the last date of pregnancy? (mm/dd/yyyy) \_\_\_\_\_  
b. How many children are/were expected with this pregnancy? \_\_\_\_\_  
c. Would you like to be referred to the program that offers food to Women, Infants and Children (WIC)?    Yes    No

24. Are you offered health coverage from a job (including someone else's job, like a parent's job)?  
 Yes. If yes, you will need to complete and include Appendix A with this application.       No

25. Do you want help paying for medical bills from the last 3 months?    Yes    No  
If yes, which month(s)? \_\_\_\_\_



If you need help with your application or to apply faster online, go to [www.kynect.ky.gov](http://www.kynect.ky.gov) or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KH8E-111

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26. Do you plan to file a federal income tax return for coverage year 2014?  
(You can apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, answer questions a & b.  NO. If no, go to question b.

a. Will you file as a single person with no dependents?  Yes  No  
If No, stop using this form. Use the *Health Coverage & Help Paying Costs Application for More Than One Person* to include your tax dependents (even if you do not want to apply for health coverage for them.)

b. Are you claimed as a dependent on someone else's tax return?  Yes  No  
If Yes, stop using this form. You will need to apply for coverage with the person claiming you on their tax return (even if that person does not want coverage.)

27. Are you a U.S. citizen or national?

Yes  No

28. If you are not a U.S. citizen or national, do you have immigration status?

Yes. Answer questions a-d below.

a. Immigration Document Type: \_\_\_\_\_

b. Document ID Number: \_\_\_\_\_

c. Have you lived in the U.S. since 1996?  Yes  No

d. Are you a veteran or active-duty member of the U.S. military?  Yes  No

29. Are you of Hispanic, Latino or Spanish origin? (OPTIONAL)  Yes  No

30. Race (OPTIONAL)

- |  |  |                                   |  |   |
|--|--|-----------------------------------|--|---|
| <input type="checkbox"/> White                     | <input type="checkbox"/> American Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese      | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Alaska Native   | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian     | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Asian Indian    | <input type="checkbox"/> Korean   | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other Pacific Islander |

31. Are you American Indian or Alaska Native?

Yes. If yes, complete Appendix C and mail it with this application.  No

32. Are you currently in prison or jail or have you been released in the past three months?

Yes. If yes, answer questions a-c.  No

a. When did you enter prison? (mm/dd/yyyy) \_\_\_\_\_

b. When did you leave prison? (mm/dd/yyyy) \_\_\_\_\_

c. Are you currently waiting for a decision on charges?  Yes  No

33. Do you need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

Yes  No

34. Are you blind or permanently disabled?  Yes  No

35. Were you receiving Medicaid when you became too old to be eligible for foster care placement?  Yes  No  
If yes, in what state were you living? \_\_\_\_\_ How old were you? \_\_\_\_\_

36. If you are filing out this application on behalf of a person who recently passed away, enter the deceased person's date of death: \_\_\_\_\_



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Form KHBE-111

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Kentucky

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## STEP 2

# Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

**Income from Job 1**

1. Who earns this income? \_\_\_\_\_ 2. Who is this person's employer? \_\_\_\_\_

3. What is the gross amount this person makes (before taxes)?  
\$ \_\_\_\_\_ 4. How often?  Weekly  Twice a month  
 Every two weeks  Monthly

5. IF SELF-EMPLOYED

a. Type of work \_\_\_\_\_

b. Gross Income \_\_\_\_\_

c. Self-employment Expenses \_\_\_\_\_

d. NET income (Gross minus expenses) \_\_\_\_\_

e. How often? \_\_\_\_\_

**Income from Job 2**

6. Who earns this income? \_\_\_\_\_ 7. Who is this person's employer? \_\_\_\_\_

8. What is the gross amount this person makes (before taxes)?  
\$ \_\_\_\_\_ 9. How often?  Weekly  Twice a month  
 Every two weeks  Monthly

10. IF SELF-EMPLOYED

a. Type of work \_\_\_\_\_

b. Gross Income \_\_\_\_\_

c. Self-employment Expenses \_\_\_\_\_

d. NET income (Gross minus expenses) \_\_\_\_\_

e. How often? \_\_\_\_\_

11. **Additional Income:** List here any additional income you may receive, give the amount and how often you get it. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. If none, leave blank.

Type of Income	How Much?	How Often?		
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Pensions	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Interest or Dividend	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Disability Payments	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Unemployment	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

12. **Household Deductions:** Give us information about things that you pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower.

Type of Deduction	How Much?	How Often?		
<input type="checkbox"/> Alimony Paid	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Student Loan Interest	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Educator Expenses	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> School Tuition and Fees	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

13. **Yearly Income:** What is your estimated yearly income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?

\$ \_\_\_\_\_



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Form KHBE-111

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## STEP 3 Other Healthcare Coverage

Do you have health coverage now, including dental and major medical coverage that is not Medicaid or KCHIP?

YES. If yes, complete the information below.

NO.

Type of coverage \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of policy holder \_\_\_\_\_

Coverage start date \_\_\_\_\_

Name of insurance company \_\_\_\_\_

Coverage end date \_\_\_\_\_

Insurance Company's Address \_\_\_\_\_

## STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit [kynect.ky.gov](http://kynect.ky.gov) or call 1-855-4kynect (459-6328) to report any changes.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

**Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (select one)

5 years (maximum allowed)  4 years  3 years  2 years  1 year

Do not use information from tax returns or other data sources to renew my coverage.

**Voter Registration:** If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

Yes, I want to apply to register to vote. An application will be mailed to me.  No, I don't want to register to vote.

**If I am eligible for Medicaid:**

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.

Signature \_\_\_\_\_

Date (mm/dd/yyyy) \_\_\_\_\_



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Form KHBE 411

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## American Indian or Alaska Native (AI/AN)

Complete this appendix if you or a family member is American Indian or Alaska Native. Submit this with your application for health coverage.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

**NOTE:** If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, MI, Last name)	First <span style="float:right">MI</span>	First <span style="float:right">MI</span>
	Last	Last
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name and state _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name and state _____ <input type="checkbox"/> No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Certain money received may not be counted for Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> <li>• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</li> <li>• Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations)</li> <li>• Money from selling things that have cultural significance</li> </ul>	\$ _____  How often? _____	\$ _____  How often? _____

If you need help with your application or to apply faster online, go to [www.kynect.ky.gov](http://www.kynect.ky.gov) or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).



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# Submission Materials for Kentucky SPA approval

June, 1 2014

TN No: 13-0007-MM2

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S94-1

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As a response to the letter that accompanied the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) transmittal KY #13-0007-MM2 Kentucky will demonstrate how we plan to address the following five issues identified regarding our application for financial assistance on kynect. These changes will be made on our Self Service Portal, Worker Portal and our paper applications.

The five items identified by CMS are:

1. Kentucky will include questions about business deductions from self-employment income in its applications to allow for a calculation of taxable self-employment income, which is the net income remaining after self-employment business expenses are deducted.
2. Kentucky will include questions about tribal income deductions allowed for American Indians and Alaska Natives (AI/ANs) in its applications.

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594-2

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3. Kentucky will restructure its applications so that all applicants who are AI/ANs are asked whether they have received services from Indian Health Service organizations, tribal health providers, and urban Indian health providers (I/T/Us), rather than requesting this information from only members of federally recognized tribes.
4. Kentucky will no longer display questions about tobacco use for applicants potentially eligible for Medicaid or CHIP.
5. Kentucky will remove questions regarding absent parents who go beyond flagging whether there is an absent parent living outside the home and whether the applying parent agrees to cooperate with medical child support enforcement post-eligibility.

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## #1 – Business Deductions for Self-Employment

- kynect is modifying our application to clearly call out self-employment expenses for the applicant. The Self Service Portal (SSP) and Worker Portal (WP) screens will be modified to allow the user to input their income, expenses and identify the frequency of their income/expenses. The net self-employment income will be calculated automatically based on the user's input for gross income, expenses and frequency period.

June, 1 2014



## Self Service Portal

Entered Total Household Income

\$ 0.00

Household Income - Self Employment Income

\*Required field

Household Income Builder Progress



How much net income (profits after expenses are paid) do these people currently make from self-employment?

Total your self employment expenses and enter that amount in the "Self-Employment Expenses" box. The total self employment net income will be automatically calculated (it is acceptable for your net income to be a negative number)

Click the button Add Income Source to add details about other self-employment you have

Member	Type of Work	Annual Income Minus Expenses	Self-Employment Income
JOHN			

\* Type of Work

\* Income and Expenses occur on this basis

Gross Income \$

\* Self-Employment Expenses \$

Net Self-Employment Income

Save & Exit

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June, 1 2014



## Worker Portal

< Back to Case Summary

Application Registration

Data Collection

Eligibility Determination

Post Confirmation

Self Employment Information

- Completed
- Income Summary
- Individual Income Type

Self Employment Information

### Self-Employment Information

Individual

Name MARY SMITH 207

Individual # 999014265

Dates

Effective Begin Date 02/01/2014 15

Effective End Date 12/31/15

Client Reported Date 05/30/2014 12

Is the change reported and verified timely?

Date Client became aware 06/01/14 15

Verification Received Date 06/01/14 15

Self-Employment Information

Self-Employment Start Date 01/01/14 15

Self-Employment End Date 12/31/15 15

Type Of Work

Are there any self employment related expenses? Yes

Total self-employment expenses \$

Self-Employment expense verification Client Statement

Note: The "Total self-employment expenses" field should include all self-employment business expenses (net income can be a negative number)

Case: 130007-15

Status Pending  
Case Mode Single  
Application Date 5/30/2014  
Renewal Date

Household Members

MARY SMITH Primary  
Age Individual # 59904265  
207 234-99-3434

LEX SMITH Daughter  
Age Individual # 59904265  
207 234-99-3434

Address  
700 Main St  
Lexington, KY 40506-0001  
502-277-3434

Contact Info

Phone  
Fax

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## Worker Portal – screen 2

### kynect

Application/Case    Home    My Account    My Applications    My Cases    My Documents    My Settings    My Profile    My Help

Application Registration    **Data Collection**    Eligibility Determination    Post Confirmation

< Back to Case Summary

Non Financial/Financial

- Questions ✓
- Income Summary ✓
- Individual Income Type ✓
- Self Employment Information ✓
- Income Pay Details Simplified** ✓

### Income Pay Details-Simplified

Case #: 100315837

Status: Pending  
Case Mode: Intake  
Application Date: 6/2/2014  
Renewal Date:

Household Members

SOMENAME T... Primary  
Age: 38    Sex: Female  
Individual #: 100315837  
SSN:

Address  
42 MILL CREEK PARK  
FRANKFORT, KY, 40601 - 9390  
FRANKLIN

Contact Info  
Phone  
E-MAIL

**Individual Information**

Name	SOMENAME TESTINGAPP 33F	Individual #	100315837
Income Type	Earned	Earned/Unearned Income Type	Self Employed
Payer	job		

**Dates**

Effective Begin Date	3/1/2014	Effective End Date	
----------------------	----------	--------------------	--

**Pay Details**

Total Gross Amount\* \$

Pay Frequency\*

June, 1 2014



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# Paper Application Changes

Family Financial Assistance Application: (page 8 )

## STEP 4 Income and Deductions

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?
3. What is the gross amount this person makes (before taxes)? \$	4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
5. IF SELF-EMPLOYED a. Type of work	b. Gross Income c. Self-employment Expenses d. NET income (Gross minus expenses)	e. How often?

Single Financial Assistance Application: (page 4)

## STEP 2 Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?
3. What is the gross amount this person makes (before taxes)? \$	4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
5. IF SELF-EMPLOYED a. Type of work	b. Gross Income c. Self-employment Expenses d. NET income (Gross minus expenses)	e. How often?

June, 1 2014



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## #2 – Tribal Income Deductions

- kynect is modifying our application to allow American Indian/Alaskan Natives to have the opportunity to enter deductions from tribal income. These deductions will only be available if individuals in the application have identified themselves as American Indian/Alaskan Natives.
- For the paper applications we have adopted the style of the federal paper applications in that we will now have an appendix for American Indian/Alaskan Natives to complete. This appendix will include a section for these deductions.

June 1 2014

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## Self Service Portal – Screen 1

Overview Applications Payments Plans & Programs Messages Assistants Settings

Application

Start Your Application

Build Your Household

**Household Income**

Entered Total Household Income **\$ 3,720.00**

**Household Income - Expenses**

Household Income Builder Progress:

Job Income Self-Employed Income Other Income Expenses

If anyone in your household includes deductions from page 1 of their income tax return, telling us about them could make the cost of health insurance a little lower. A few examples include:

- ✓ Alimony
- ✓ Student Loan Interest
- ✓ Educator Expenses
- ✓ Post High School Tuition and Fees (only if claimed as a tax deduction on page 1 of your tax return)

American Indian/Alaskan Native (AI/AN) income to deduct includes: Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties, payments earned from land designated as Indian land by the Department of Interior, money from selling things that have cultural significance.

Check the box next to anyone who currently pays for one of the expenses listed above.

Household Member	Has Expenses
<input type="checkbox"/>	<input type="checkbox"/>

JOIN

Save & Exit

Back Next

June, 1 2014



## Self Service Portal – Screen 2

**Application**

- Start Your Application
- Build Your Household
- Household Income

**Entered Total Household Income** \$ 0.00

**Household Income - Expenses** \* Required Field

Household Income Builder Progress:

Job Income
Self Employed Income
Other Income
Expenses

If anyone in your household includes deductions from page 1 of their income tax return, telling us about them could make the cost of health insurance a little lower. A few examples include:

- ✓ Alimony
- ✓ Student Loan Interest
- ✓ Educator Expenses
- ✓ Post High School Tuition and Fees (only if claimed as a tax deduction on page 1 of your tax return)

American Indian/Alaskan Native (AIAN) income to deduct includes Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties, payments earned from land designated as Indian land by the Department of Interior, money from selling things that have cultural significance.

Click the button **Add Expense** to add details about expenses any of these people currently pay.

Member	Source	Annual Expense	Expenses
DRLY			<b>Add Expense</b>

\* Source: - Select -

- Alimony Paid
- Student Loan Interest
- Educator Expenses
- Health Insurance Premiums
- American Indian/Alaskan Native Expenses

\* Expense Amount:

**Save & Exit**
**< Back**
**Next >**

June, 1 2014





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## Paper Applications – Appendix C

<p>4. Certain money received may not be counted for Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). List any income (amount and how often) reported on your application that includes money from these sources:</p> <ul style="list-style-type: none"><li>• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</li><li>• Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations)</li><li>• Money from selling things that have cultural significance</li></ul>	<p>\$ _____</p> <p>How often?</p> <p>_____</p>	<p>\$ _____</p> <p>How often?</p> <p>_____</p>
--	--	--

June, 1 2014

TN No: 13-0007-MM2

Kentucky

Approval Date: 09/05/14

S94-13

Effective Date: 01/01/14



kynect

Kentucky Health  
Benefit Exchange



## #3 – Indian Health Services, etc.

- kynect is modifying our application to ask all American Indians/Alaskan Natives if they have ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs. If they answer no to that question then we will also ask if this person is eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?
- For the paper applications we have adopted the style of the federal paper applications in that we will now have an appendix for American Indian/Alaskan Natives to complete. This appendix will include a section regarding these services.

June, 1 2014



## Self Service Portal

**kynect** My Account Browse Plans Learn More Get Help | Welcome John Doe | Log Out | About | Help | ENGLISH ▼

Overview Applications Payments Plans & Programs Messages Assistants Settings

Application

Start Your Application

Household

Results

Find A Plan

Enrollment

### American Indian, Alaskan Native Information

\* Required Field

\* Is any member of your household an American Indian or Alaskan Native?

Yes  No

Who is an American Indian or Alaskan Native?

John  Jane

Mary  Johnny

John

\* Is John a member of a federally recognized tribe, band, nation, community or other group?

Yes  No

\* Has John ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

Yes  No

\* Is John eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

Yes  No

**Save & Exit** **Back** **Next**

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June, 1 2014

TN No: 13-0007-MM2

Kentucky

Approval Date: 09/05/14

S94-15

Effective Date: 01/01/14

# kynect

Kentucky Health  
Benefit Exchange



## Worker Portal

**NOTE – the second question regarding eligibility for Indian Health Services is only enabled if the first question regarding receipt of services is answered no.**

Applications Registration | Data Collection | Eligibility Determination | Post Certification

**Individual** ↕ ?

**Application Information**

Primary Applicant: DAVID DAVID      Application #: 200010225

**Individual Search**

SSN: [ ]      Individual #: [ ]      **Search**

**Identifying Information**

First\*: DAVID      Middle Initial: [ ]  
Last\*: DAVIS      Suffix: [ ]  
Gender\*: [ ]  
Date of birth\*: [ ]  
SSN: [ ]      Reason for not providing SSN: [ ]  
Date of HUD or HHS: [ ]

**Individual Information**

Residence: [ ]       American Indian or Alaska N.      Nationality: [ ]  
Age: [ ]       Alaska      Ethnicity Type: [ ]  
Citizenship: [ ]      Spoken Language\*: English [ ]

Member of a federally recognized tribe, band, nation, community, etc.  
Received services from Indian Health Service, tribal health program, urban health program, or through a referral from one of these programs?      No [ ]  
Yes [ ]

City, Co. or service received from an Indian Health Service, tribal health program, urban health program, or through a referral from one of these programs?      No [ ]  
Yes [ ]

Tribe/State: [ ]  
If deceased: (Date of Death): [ ]

**Next**      **Cancel**

June, 1 2014

13-0007-MM2

.y

Approval Date: 09/05/14

COA-1C

Effective Date: 01/01/14



## Paper Applications – Appendix C

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

- Yes  
 No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

- Yes       No

- Yes  
 No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

- Yes       No



# kynect

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## #4 – Tobacco Question for Medicaid/CHIP Individuals

- As part of our application changes kynect will be developing a Post-Eligibility module. This will enable us to ask program specific questions once an individual's eligibility has been determined. The tobacco usage question will now be able to be asked of only individuals eligible to shop for Qualified Health Plans.

June, 1 2014



## Self Service Portal

Start Your Application

### Eligibility-specific Questions

Results

Find A Plan

Enrollment

Your eligibility has already been determined. You just need to answer the following program specific questions.

#### Tobacco Use Information

If you are eligible for payment assistance or a full-priced health insurance plan, you need to respond to these questions to view accurate rates. If you are Medicaid eligible, you do not need to respond to these questions.

Has any member of your household used tobacco at least 4 times a week in the past 6 months?

Yes  No

Who uses tobacco?

John

Jane

Mary

Johnny

Next ▶

June, 1 2014

TN No: 13-0007-MM2

Kentucky

Approval Date: 09/05/14

S94-19

Effective Date: 01/01/14



## Worker Portal

< Back to Case Summary

Application Registration

Data Collection

Eligibility Determination

Final Confirmation

Eligibility Determination

Non-Eligible



Eligible Summary



Medicaid Questions



QHP Questions

### QHP Program Specific Questions

#### QHP Questions

In order to determine the most accurate plan costs, an individual who is eligible for payment assistance or a full-price health insurance plan must answer the question below.

Has any member of your household used tobacco at least 4 times a week in the past 6 months?

Yes



Case# 100-03517

Status: Pending  
Case Mode: Initial  
Application Date: 5/20/2014  
Revised Date:

#### Household Members

**MARY SMITH** Primary  
Age: 44  
Individual ID: 99994765  
SSN: 234-56-7890  
Sex: Female

**LIZ SMITH** Daughter  
Age: 17  
Individual ID: 99994766  
SSN: 789-01-2345  
Sex: Female

Address:  
2345 MAIN ST  
LEXINGTON, KY 40506 0001  
90212

#### Contact Info

Phone:  
8-1111

Previous

Next

June, 1 2014



**kynect**

Kentucky Health  
Benefit Exchange



## Paper Applications

- The tobacco usage question has been removed from both the family and single financial assistance application.

June, 1 2014



Kentucky Health  
Benefit Exchange



## #5 – Medical Support Enforcement

- kynect will modify our application to only ask the appropriate individuals MSE questions in the Pre-Eligibility component if they agree to cooperate with medical support enforcement and if answered No, they may answer if they have good cause for not cooperating.
- Then in our Post-Eligibility module we will ask additional optional questions regarding the non-custodial parent. The individual's response to these Post-Eligibility questions does not affect their eligibility. If they have good cause for not cooperating they will not be asked these Post-Eligibility questions.

June, 1 2014



Kentucky Health  
Benefit Exchange



# Self Service Portal – Pre-Eligibility

**kynect**    My Account    Browse Plans    Learn More    Get Help

Overview    Applications    Payments    Plans & Programs    Messages    Assistants    Settings

**Application**

- Start Your Application
- Build Your Household
- Household Income
- Additional Questions**

**Medical Support Information** \*\*Required Data

It looks like [NAME] has a parent that is not living in the home. Please provide details below on your willingness to cooperate with Medical Support Enforcement.



CHLD

**CHLD's Mother**

**Cooperation with Medical Support**

By accepting Medical Assistance, you assign (give) CHFS rights to enforce medical support from the child's absent parent(s). You must help CHFS find the absent parent(s) unless there is a good reason not to do so, such as domestic violence. If it is decided that you have to work with the Child Support Office to establish or enforce child support and you do not, you may lose medical assistance.

Do you agree to cooperate with Medical Support?     No     Yes

Reason for not Cooperating?   

Comments

**Save & Exit**    **Back**    **Next**

June 1 2014

TN No: 13-0007-MM2

Kentucky

Approval Date: 09/05/14

S94-23

Effective Date: 01/01/14



Kentucky Health  
Benefit Exchange



## Self Service Portal – Post-Eligibility (optional questions)

Overview Applications Payments Plans & Programs Messages Assistants Settings

Case 100123919

**Your eligibility has already been determined. You just need to answer the following program specific questions.**

**More About Parents** \*Required field

It looks like CHILD has a parent that is not living in your home. Please give us some more information.

  
CHILD

**CHILD's Mother**

If unknown, please click here

First Name  MI  Last Name  Suffix

Date Of Birth  Social Security Number (SSN)

If CHILD's mother is deceased, please click here

Place of Employment

Why is CHILD's Mother not in the home?

Current or Last Known Address

Address Line 1

Address Line 2

City  State  Zip Code  County

June 1 2014

TN No: 13-0007-MM2  
Kentucky

Approval Date: 09/05/14  
594-24

Effective Date: 01/01/14





Kentucky Health Benefit Exchange



# Worker Portal – Post-Eligibility (optional questions)



Home | My Account | My Applications | My Information | My Documents | My Profile | My Settings | My Support | My Help

[Back to Case Summary](#)

Application Registration

Data Collection

Eligibility Determination

Post Confirmation

### Eligibility Determination

- Run Eligibility ✓
- Eligibility Summary ✓
- Medicaid Questions ✓
- QHP Questions ✓

### Non-Custodial Parent Information

View Information | Print

## Non-Custodial Parent Information

### Non-Custodial Parent

Non-Custodial Parent Is Unknown:  Yes  No

First Name: Unknown Middle Initial: \_\_\_\_\_

Last Name: Unknown Suffix: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female

### Last Known Address

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

ZIP Code: \_\_\_\_\_ Country: \_\_\_\_\_

### Non-Custodial Parent Summary

First Name	Last Name	Address	Birthdate
Unknown	Unknown	Unknown	Unknown

Case: 100004151

Status: Pending  
 Case Mode: Intake  
 Application Date: 5/20/2014  
 Renewal Date: \_\_\_\_\_

### Household Members

Name	Role	Age	Individual ID	SSN
MARY SMITH	Primary	35	999014755	284-36-2454
LIZ SMITH	Daughter	1	999014756	752-30-0473

Address:  
 2848 PALM DR  
 LEXINGTON, KY 40506 - 0001  
 FAYETTE

### Contact Info

Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

Back Next

Previous Next

June, 1 2014

TN No: 13-0007-MM2  
Kentucky

Approval Date: 09/05/14  
S94-26

Effective Date: 01/01/14



Kentucky Health  
Benefit Exchange



## Worker Portal – Post-Eligibility (optional questions screen 2)

Application Registration | Data Collection | Eligibility Determination | Post Confirmation

### Non-Custodial Parent Relationship Information

**Case:** 20140114

**Status:** Pending  
**Case Mode:** Initial  
**Applies when Date:** 1/30/2014  
**Revised Date:**

**Member Info:** LIZ SMITH OF 997014768

**Effective Begin Date:** 01/01/2014 **Effective End Date:**

**Non-Custodial Parent Relationship Information**

LIZ SMITH's Non-Custodial Parent is\*

Non-Custodial Parent Status regarding LIZ SMITH

Is the responsible individual cooperating?  Yes  No

Good Cause  Yes  No

Submit Reason for Non-Cooperation

**Save** **Cancel**

**Relationship Summary**

Child Name	Non-Custodial Parent	Non-Custodial Parent Status	Actions

**Print** **Close**

**NOTE – the three questions about cooperation, good cause and cooperation verification are read only fields and are only repeated here to assist workers in remembering what was previously entered Pre-Eligibility.**

June, 1 2014

TR: 13-0007-MM2  
Kentucky

Approval Date: 09/05/14  
594.77

Effective Date: 01/01/14



Kentucky Health  
Benefit Exchange



## Paper Applications

- **Family Financial Assistance Application**

- These questions have not changed, they are in the signature portion of the paper application for families

**If anyone on this application is eligible for Medicaid or KCHIP:**

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.
- Does any child on this application have a parent living outside of the home?  Yes  No
- If yes, I give the Cabinet for Health and Family Services (CHFS), Child Support Office, the right to enforce medical support from the child's absent parent(s). If I think that cooperating with the Child Support Office will harm me or my children, I can tell CHFS and I may not have to cooperate.

- **Single Financial Assistance Application**

- Since this application is for a single individual there are not cooperation with medical support enforcement questions. No modifications have been made to this application.

June, 1 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4120  
Atlanta, GA 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

September 19, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001



COPIES TO  
LISA, NEVIN  
SHERIDAN, VERONICA  
MAC

FBI  
9/25/14

Dear Mr. Kissner:

On November 6, 2013, the Centers for Medicare & Medicaid Services (CMS) approved Kentucky's State Plan Amendment (SPA) 13-0007-MM2 with an effective date of January 1, 2014. This SPA included approval for the state to use interim alternative single streamlined online and paper applications until June 30, 2014.

The CMS has reviewed the changes submitted with respect to Kentucky's alternative single streamlined online and paper applications. The revised applications address the concerns outlined in the companion letter that was issued with the SPA's approval. This letter serves as official approval of Kentucky's alternative single streamlined online application and alternative single streamlined paper application.

Enclosed is a copy of the approved application materials. Please incorporate these pages into the State Plan following the attachments to S94 entitled, "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact Melanie Benning at 404-562-7414 or [Melanie.Benning@cms.hhs.gov](mailto:Melanie.Benning@cms.hhs.gov).

Sincerely,

Jackie Glaze  
Associate Regional Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4120  
Atlanta, GA 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

September 19, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001



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Sincerely,

Jackie Glaze  
Associate Regional Administrator

Enclosure



Kentucky Health  
Benefit Exchange



## Worker Portal – Post-Eligibility (optional questions)

**kynect** Home Application Status My Account My Profile My Documents My Settings My Account Settings My Profile Settings My Documents Settings My Settings Settings

Application Registration Data Collection **Post-Eligibility Questions** Post Confirmation

← Back to Case Summary

### Non-Custodial Parent Information

**Non-Custodial Parent**

Is Non-Custodial Parent in  
Jurisdiction?  Yes

First Name:  MIDDLE SMITH

Last Name:  SMITH

SSN:  999-99-9999

Gender:

**Last Known Address**

Address Line 1:

Address Line 2:

City:  STATE:

ZIP Code:  County:

**Non-Custodial Parent Summary**

First Name	Last Name	Address	Actions
			<input type="button" value="Edit"/> <input type="button" value="Delete"/>

June 1 2014

TN No: 13-0007-MM2  
Kentucky

Approval Date: 09/05/14  
S94-26

Effective Date: 01/01/14



Kentucky Health  
Benefit Exchange



## Worker Portal – Post-Eligibility (optional questions screen 2)

Non-Custodial Parent Relationship Information

JAC SMITH

1. Do you have any other children?  Yes  No

2. Do you have any other dependents?  Yes  No

3. Do you have any other health insurance?  Yes  No

Back Next

**NOTE – the three questions about cooperation, good cause and cooperation verification are read only fields and are only repeated here to assist workers in remembering what was previously entered Pre-Eligibility.**

January 1, 2014



Kentucky Health  
Benefits Exchange



## Paper Applications

- **Family Financial Assistance Application**

- These questions have not changed, they are in the signature portion of the paper application for families

**If anyone on this application is eligible for Medicaid or KCHIP:**

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.
- Does any child on this application have a parent living outside of the home?  Yes  No
- If yes, I give the Cabinet for Health and Family Services (CHFS), Child Support Office, the right to enforce medical support from the child's absent parent(s). If I think that cooperating with the Child Support Office will harm me or my children, I can tell CHFS and I may not have to cooperate.

- **Single Financial Assistance Application**

- Since this application is for a single individual there are not cooperation with medical support enforcement questions. No modifications have been made to this application.

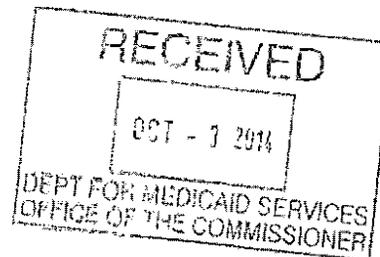
DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

September 30, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
Attn: Leslie Hoffman  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001



Dear Mr. Kissner:

This letter is in response to your September 25, 2014 letter concerning the termination of Kentucky's Home and Community-Based Services (HCBS) Transitions Waiver, control number 0967.R00.00. The state's requested effective date of termination is October 25, 2014.

The Centers for Medicare & Medicaid Services (CMS) acknowledges the information provided by the state regarding the requested termination. Specifically, the state has not enrolled any participants in this waiver since the waiver's approval. The state has successfully transitioned the waiver's target population, individuals who are elderly and/or disabled, from long-term care facilities into the community through existing 1915(c) waivers and the Money Follows the Person Rebalancing Demonstration Grant Program.

The CMS would like to thank the Division of Community Alternatives' staff for the diligent work throughout this process. Please do not hesitate to contact Melanie Benning at 404-562-7414 with any additional questions or issues regarding the termination of HCBS Waiver, 0967.R00.00.

Sincerely,

A handwritten signature in cursive script that reads "Charlie Arnold".

*for* Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Michele MacKenzie, Central Office

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop: S2-01-16  
Baltimore, Maryland 21244-1850

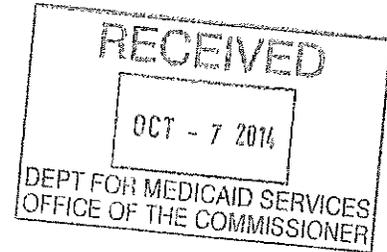


FIVE  
CM

**Children and Adults Health Programs Group**

**OCT 01 2014**

Mr. Lawrence Kissner  
Commissioner, Department for Medicaid Services  
Cabinet for Health and Family Services  
275 East Main Street, 6 West A  
Frankfort, KY 40621



Dear Mr. Kissner:

On behalf of the Centers for Medicare & Medicaid Services Modified Adjusted Gross Income (MAGI) Conversion Team, thank you for your assistance in the current MAGI Conversion exercise to convert your current Medically Needy income standards from the Aid to Families with Dependent Children (AFDC)-based methodology to a new MAGI-based methodology. Attached please find the results of the conversion of your medically needy standards for the medically needy populations you identified in the template you completed.

Financial eligibility determinations for the non-aged, blind and disabled, medically needy groups (pregnant women, children under the age of 18, 18 - 20 year olds, and parents/caretaker relatives), were historically based on the methodologies of the former AFDC program. However, with the elimination of the AFDC program and the replacement of AFDC-based methodologies with MAGI-based methodologies for determining financial eligibility for categorically needy families and children, we proposed revisions to the regulations at 42 CFR section 435.831 (Medically Needy Income Eligibility) in order to provide states with the option to apply either AFDC-based methods or MAGI-based methods for determining income eligibility for medically needy children, pregnant women, and parents/caretaker relatives.

We anticipate finalizing this policy in regulation soon. States will then have the choice to use the newly converted standards, or retain the limits already approved in their state plan. If the state decides to adopt the newly converted MAGI-based standards, the state is required to submit a state plan amendment requesting the income standards be updated to reflect the new limits. We note that because the medically needy are MAGI-exempt in statute, the proposal to adopt a "MAGI-like" methodology retains two elements of the AFDC-based income standards: first, the Medicaid prohibited deeming rules; and, second, the option to apply a resource test.

We ask that you review the attached MAGI converted standards to determine whether the conversion meets your expectations or appears to be different than what you had expected. If you believe that any revision is needed, please notify us within 5 days of receipt of these results.

Page 2 – Mr. Lawrence Kissner

Please do not hesitate to contact Stephanie Kaminsky at [Stephanie.Kaminsky@cms.hhs.gov](mailto:Stephanie.Kaminsky@cms.hhs.gov) or 410-786-0617 if you have any questions or comments.

Once again, thank you for your assistance in this process.

Sincerely,

Handwritten signature of Eliot Fishman in cursive script.Handwritten initials 'ae' enclosed in a circle.

Eliot Fishman  
Director

cc:  
Jackie Glaze, ARA, Atlanta Regional Office

KY: converted thresholds  
 Date: September 10, 2014

Population/Type	Citation	Unit Size	Original Standard	Converted Standard
Medically Needy Pregnant	1902(a)(10)(C)	1	\$217	\$236
		2	\$267	\$293
		3	\$308	\$341
		4	\$383	\$422
		5	\$450	\$496
		6	\$508	\$561
		7	\$567	\$627
		8	\$627	\$693
		Add-on	\$60	\$67
Medically Needy Children 0-17	1902(a)(10)(C)	1	\$217	\$240
		2	\$267	\$298
		3	\$308	\$347
		4	\$383	\$429
		5	\$450	\$504
		6	\$508	\$570
		7	\$567	\$637
		8	\$627	\$705
		Add-on	\$60	\$68
Medically Needy Parents or Caretaker Relatives	1902(a)(10)(C)	1	\$217	\$245
		2	\$267	\$305
		3	\$308	\$356
		4	\$383	\$441
		5	\$450	\$517
		6	\$508	\$585
		7	\$567	\$654
		8	\$627	\$724
		Add-on	\$60	\$70

KY: converted thresholds  
 Date: September 10, 2014

Population/Type	Disregard Type	Citation	Unit Size	Original Standard	Converted Standard
Medically Needy Pregnant	With time-limited disregards (\$30 and 1/3)	1902(a)(10)(C)	1	\$217	\$252
			2	\$267	\$315
			3	\$308	\$368
			4	\$383	\$455
			5	\$450	\$534
			6	\$508	\$605
			7	\$567	\$676
			8	\$627	\$748
			Add-on	\$60	\$72
	With time-limited disregards (\$30)	1902(a)(10)(C)	1	\$217	\$235
			2	\$267	\$291
			3	\$308	\$338
			4	\$383	\$419
			5	\$450	\$492
			6	\$508	\$556
7			\$567	\$621	
8			\$627	\$687	
Add-on	\$60	\$66			
Medically Needy Children 0-17	With time-limited disregards (\$30 and 1/3)	1902(a)(10)(C)	1	\$217	\$255
			2	\$267	\$318
			3	\$308	\$373
			4	\$383	\$461
			5	\$450	\$541
			6	\$508	\$612
			7	\$567	\$684
			8	\$627	\$758
			Add-on	\$60	\$73
	With time-limited disregards (\$30)	1902(a)(10)(C)	1	\$217	\$238
			2	\$267	\$295
			3	\$308	\$344
			4	\$383	\$426
			5	\$450	\$500
			6	\$508	\$566
7			\$567	\$632	
8			\$627	\$699	
Add-on	\$60	\$67			
Medically Needy Parents or Caretaker Relatives	With time-limited disregards (\$30 and 1/3)	1902(a)(10)(C)	1	\$217	\$264
			2	\$267	\$331
			3	\$308	\$388
			4	\$383	\$479
			5	\$450	\$563
			6	\$508	\$637
			7	\$567	\$712
			8	\$627	\$788
			Add-on	\$60	\$76
	With time-limited disregards (\$30)	1902(a)(10)(C)	1	\$217	\$243
			2	\$267	\$302
			3	\$308	\$352
			4	\$383	\$436
			5	\$450	\$512
			6	\$508	\$580
7			\$567	\$648	
8			\$627	\$717	
Add-on	\$60	\$69			

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

---

October 22, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
Attn: Leslie Hoffman  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001

RE: 372 Acceptance letter – KY 0333

Dear Mr. Kissner,

We have completed our review of your CMS 372 annual report for the Home and Community-Based Services (HCBS) Waiver listed below. Based on our analysis of the expenditure and recipient data submitted in this report, we find the data acceptable, subject to any future data validation reviews. A comparison of the actual data reported to the most recent CMS-approved estimates indicates that the estimated costs without the waiver were not exceeded.

- **0333 Acquired Brain Injury Waiver**  
(Waiver Year 1 – 01/01/12 – 12/31/12)

If you have any questions, please contact Melanie Benning at 404-562-7414.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze". The signature is written in a cursive, flowing style.

Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Michele MacKenzie, Central Office

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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October 22, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
Attn: Leslie Hoffman  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001

RE: 372 Acceptance letter – KY 0314

Dear Mr. Kissner,

We have completed our review of your CMS 372 annual report for the Home and Community-Based Services (HCBS) Waiver listed below. Based on our analysis of the expenditure and recipient data submitted in this report, we find the data acceptable, subject to any future data validation reviews. A comparison of the actual data reported to the most recent CMS-approved estimates indicates that the estimated costs without the waiver were not exceeded.

- **0314 Supports for Community Living Waiver**  
(Waiver Year 1 – 09/01/10 – 08/31/11)

If you have any questions, please contact Melanie Benning at 404-562-7414.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze". The signature is written in a cursive, flowing style.

Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

cc: Michele MacKenzie, Central Office

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-14-26  
Baltimore, Maryland 21244-1850



Disabled & Elderly Health Programs Group

OCT 27 2014



Mr. Lawrence Kissner, Commissioner  
Cabinet for Health and Family Services  
Department for Medicaid Services  
275 East Main Street, 6W-A  
Frankfort, KY 40621

Dear Mr. Kissner:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated October 22, 2014, for a temporary extension of Kentucky's Medicaid Managed Care 1915(b) waiver program under CMS control number KY-07. The current temporary waiver authority expires on October 31, 2014. You have requested this extension to ensure the Kentucky Department for Medicaid Services has adequate time to submit contract and actuarial certifications to CMS for review in order to obtain CMS approval of managed care capitation rates.

The CMS is granting an extension of the KY-07 waiver to operate the managed care program under section 1915(b) of the Social Security Act (the Act). This temporary extension will expire on January 31, 2015. Prior to the expiration of the temporary extension, please submit a complete managed care renewal waiver application, including the cost effectiveness spreadsheets, the Section D description of the cost effectiveness test, data from the state's monitoring activities, and incorporate the recommendations for improvement from the Independent Assessment into the waiver application.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage, in the Atlanta Regional Office, at (404) 562-7116, or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,

Barbara Coulter Edwards  
Director

cc: Cheryl Brimage, Atlanta Regional Office  
Shantrina Roberts, Atlanta Regional Office  
Jackie Glaze, Atlanta Regional Office

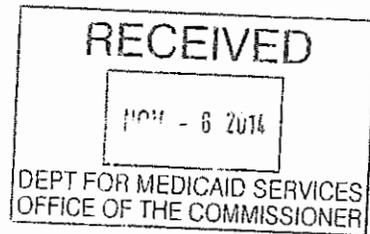
DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth St., Suite 4T20  
Atlanta, Georgia 30303-8909



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

October 31, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001



Re: Kentucky Non-Emergency Transportation Waiver 06-R02

Dear Mr. Kissner:

We accept your request, dated October 31, 2014, to withdraw the Non-Emergency Transportation Waiver application, KY-06.R02, submitted on September 18, 2014.

If you have any questions or need any further assistance, please contact Cheryl Brimage at (404) 562-7116.

Sincerely,

A handwritten signature in cursive script that reads "Jackie Glaze".

Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations