MAP-INC
(6/21)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Incarceration Status Correction

Today's Date: _____

Name of person reporting Status change: _____

Phone number of person reporting change _____

Member name (first, middle, last & suffix): _____

Medicaid Case Number or Social Security Number _____

MEMBER INCARCERATION BEGIN AND END DATES

FROM: _____ TO: _____

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

You may fax this form to 1-502-564-0039 or send by US postal service to: Department for Medicaid Services, Incarceration/Eligibility Services, 275 East Main St, 6W-D, Frankfort, KY 40621

Reminder: If you have additional changes to report in your household situation log into the Self-Service Portal at https://kynect.ky.gov/ or call kynect at 1-855-459-6328 or DCBS at 1-855-306-8959. You may also visit a Department for Community Based Services (DCBS) office. To find a DCBS office near you go to https://prd.webapps.chfs.ky.gov/Office_Phone/

_____ _____

Signature of Medicaid member or authorized representative

Date