MAP-INC
(1/22)

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

Incarceration Status Correction

Today's Date: _____

Name/relationship of person reporting change: _____

Email address of person reporting change: _____

Phone number of person reporting change: _____

Medicaid 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 submit this form by fax to 1-502-564-0039, email to DMS.eligibility@ky.gov, 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 you can log into the Self-Service Portal at https://kynect.ky.gov, call kynect at 1-855-459-6328, or call the Department for Community Based Services (DCBS) at 1-855-306-8959. You may also visit your local DCBS office.

_____ _____

Signature of Medicaid member or authorized representative **Date**