

## Correctional Facility Inmate – Qualifying Event

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This form shall be used to report an inpatient hospital stay for an inmate of a correctional facility administered by either the Kansas Department of Corrections (KDOC) or the Kansas Juvenile Justice Authority (JJA). This form shall be attached as a supplement to the initial ES-3100.1 or HealthWave medical assistance application form filed with KDHE-DHCF. The form shall also be submitted to KDHE-DHCF whenever an additional qualifying event occurs within an established 12 month eligibility period and there have been no substantial changes in financial circumstances.

**Identifying Information:**

Name of Applicant: \_\_\_\_\_  
(First Name) (Middle Initial) (Last Name)  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Inmate #: \_\_\_\_\_  
(Day/Month/Year)  
Mailing Address: \_\_\_\_\_

**Correctional Facility:**

Name of Facility: \_\_\_\_\_  
Address of Facility: \_\_\_\_\_  
Facility Contact (Facilitator): \_\_\_\_\_  
(First Name) (Last Name) (Title)  
Date Incarceration Began: \_\_\_\_\_ In Custody of: \_\_\_ KDOC \_\_\_ JJA  
(Day/Month/Year)

**Qualifying Event:**

Hospital: \_\_\_\_\_  
Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
(Day/Month/Year) (Day/Month/Year)  
Reason for Stay: \_\_\_\_\_  
\_\_\_\_\_

**I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.**

\_\_\_\_\_  
Signature of Applicant Date

\_\_\_\_\_  
Signature of Facilitator Date