INFORMATION DISCLOSURE FORM

(Print in Black or Blue Ink)

Please Mail To:	SRS/DBHS - Parent Fee Program 915 SW Harrison, 9th Floor West Topeka, KS 66612-1570	**Contact for Questions** **Phone:** (785) 296-3536 **E-Mail:** ParentFee@srs.ks.gov

Participant Information

Name(s) of All Children Receiving Waiver Services			Age	Date of Birth	Medicaid ID #	SSN #	HCBS Wavier (See Key Below)	Relationship (See Key Below)
First	MI	Last						
EXAMPLE -- Jed	E.	Doe	13	7/5/1996	00000000000	123-45-6789	DD	AC
							Autism	Daughter/s
							Autism	Daughter/s
							Autism	Daughter/s
							Autism	Daughter/s

List Additional Participants On Separate Page

HCBS Waiver Program Key		Relationship Key	
AUT - Autism	**SED -** Serious Emotional Disturbance	**D -** Daughter/Step-Daughter	**S -** Son/Step-Son
DEV - Developmental Disability/Mental Retardation	**TA -** Technology Assistance	**AC -** Adopted Child	**FOS -** Foster Child
PHY - Physical Disability	**TBI -** Traumatic Brain Injury	**O -** Other (Specify):	

Information of Individual Responsible for Fee Payment

Parent/Guardian Name:	Social Security Number:
Address:	City, State, ZIP:
Daytime Phone Number: ( )	E-Mail:

Did You File Income Tax Last Year **(Attach a copy of the first page of your Federal Income Tax Return)**	☐ **Yes**	Per Tax Return Adjusted Gross Income $_____	# of Exemptions (family size) ____
	☐ **No**	Estimate Adjusted Gross Income $_____	# of Exemptions (family size) ____

I do not believe a Parent Fee should be charged for the following reason(s). Check all that apply

☐ Child is in foster care ☐ Relative other than a parent or step-parent ☐ Child is adopted ***(provide copy of Adoption Decree)***

The information I have given is true and correct to the best of my knowledge

Print Name:		**Signature/ Certification:**		**Date:**	