

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Medicaid Services

**MEDICAID WORK OR COMMUNITY ENGAGEMENT
SHORT-TERM HARDSHIP EXEMPTION REQUEST FORM**

INDIVIDUAL INFORMATION

Name	
Date of Birth (MM/DD/YYYY)	
SSN	
Case Number	
Address	

SHORT-TERM HARDSHIP EXEMPTION CATEGORY

- ☐ Category A - Inpatient Care: Select one option below
- ☐ I am in a hospital or other inpatient medical facility now
 - ☐ I was admitted to or received inpatient care at a hospital or medical facility during a month I had to meet the work or community engagement requirement.

Facility Name:		Admission Date (MM/DD/YYYY):	
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- ☐ Category B - Federal Emergency or Disaster: I live or have lived in a county covered by a federally declared emergency or disaster during a month I had to meet the work or community engagement requirement.

County of Residence:	Choose a County of Residence
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- ☐ Category C - High Unemployment County: I live in a county where the unemployment rate exceeds the federal threshold during a month I had to meet the work or community engagement requirement.

County of Residence:	
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- ☐ Category D - Extended Travel for Specialized Medical Care: I must travel more than 25 miles from my home for more than 1 week or 5 business days to receive specialized medical treatment for myself or a dependent during a month I had to meet the work or community engagement requirement.

Patient Name: (if dependent, include relationship)		Provider Name and Location:	
Approximate Start Date: (MM/DD/YYYY)		Approximate End Date: (MM/DD/YYYY) If unknown, write N/A	

ATTESTATION

I certify under penalty of law that the information above is true and accurate to the best of my knowledge. I understand that a short-term hardship exemption is temporary and that the Medicaid work or community engagement requirement will apply again once the short-term hardship ends. False information may result in penalties under 42 U.S.C. § 1320a-7b and KRS 205.8459.

Signature	Date (MM/DD/YYYY)
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Privacy Act Disclosure Statement: The information on this form is collected under the authority of the Social Security Act for purposes of administering the Medicaid program. It will be used by Kentucky Medicaid to verify participation in work or community engagement activities and determine program compliance. Providing this information is voluntary; however, failure to provide the requested information may delay or prevent verification. Information may be shared with authorized state and federal agencies and contractors for program administration as permitted by law.

How to Submit this Form

The individual should return the completed form in one of five ways:

- Log into their Self-Service Portal at <<https://kynect.ky.gov/benefits>>;
- Visit a local Department for Community Based Service (DCBS) office; you can find one near you at <https://prd.webapps.chfs.ky.gov/Office_Phone/index.aspx>;
- Get help from a kynector; you can find one by calling 1-855-459-6328 or at <<https://kynect.ky.gov/benefits/s/auth-reps-assisters>>;
- Fax this form to 1-502-573-2005 or 502-573-2007; or
- Mail this form to PO Box 2104, Frankfort, KY 40602.

Questions? Call kynect at 1-855-459-6328 (Mon – Fri, 8:00a.m. - 7:00p.m ET) or DCBS at 1-855-306-8959 (Mon–Fri, 8:00 a.m.–4:30 p.m. ET)

More information about the Medicaid Work or Community Engagement requirement is available online <https://khbe.ky.gov/Enrollment/Pages/MedicaidWorkCE.aspx> (www.MedicaidWorkCE.ky.gov).