

Commonwealth of Kentucky  
Cabinet for Health and Family Services  
Department for Medicaid Services  
<https://chfs.ky.gov/>  
**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 **502-564-0039** or send by U.S. 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 855-459-6328 or DCBS at 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/](https://prd.webapps.chfs.ky.gov/Office_Phone/)

\_\_\_\_\_  
Signature of Medicaid member or authorized  
representative

\_\_\_\_\_  
Date