KANSAS CHARITABLE HEALTH CARE PROVIDER PROGRAM

Independent Charitable Health Care Provider Agreement

For more information: http://www.kdheks.gov/olrh/CHP.htm

Email questions to: kdhe.primarycare@ks.gov

Health Care Provider Full Name: _____

Profession: (MD, RN, APRN, DDS, etc.)_____ License Number:_____

Address: _____ City: _____ KS Zip: _____

Phone: _____ Email: _____

In 1991 Kansas enacted legislation allowing indigent health care clinics and charitable health care providers to receive limited medical liability coverage under the Kansas Tort Claims Act. My signature on this agreement constitutes my intention to provide charitable health care to medically indigent patients as an independent health care provider not providing services at an indigent health care clinic.

I understand that in order to be considered gratuitous, I may not charge the patient or individually submit a claim for those patients with public or private insurance. Nothing in this agreement waives my right to bill insurance or an individual patient for services provided when that care is not provided as part of my participation in the Charitable Health Care Provider Program. I understand it is my responsibility to maintain patient records for services I provide as a charitable health care provider and that I must:

- determine that individuals seen as part of my participation in the Charitable Health Care Provider Program are medically indigent; and
- submit an annual activity report to KDHE (KAR 28-53-1).

NOTE: If an indigent health care clinic, its employee(s), or a charitable health care provider is sued by the recipient of care, they must request representation from the state in writing within 15 days after service of process or subpoena (KSA 75-6108(e)). Indigent health care clinics, their employee(s), or charitable health care providers served with a summons or petition should immediately contact the Kansas Attorney General's office at 785-296-2215.

I certify that the information provided is accurate and complete to the best of my knowledge.

_____ _____
Signature of Health Care Provider Date

_____
Printed Name of Health Care Provider

_____ _____
Janet Stanek, Secretary Date
Kansas Department of Health and Environment

Return all documents to:

Charitable Health Care Provider Program
Bureau of Community Health Systems
Kansas Department of Health and Environment
1000 SW Jackson St, Ste 340
Topeka, KS 66612-1365

Email: kdhe.primarycare@ks.gov
Fax: 785-559-4247