

Kansas State Treasurer's Collections Remittance System User Security Access Request

General Information:

- ❖ This form will grant your facility access to the Kansas State Treasurer's Collections Remittance System (CRS), in order to make Quality Care Assessment and Medicaid Provider Enrollment fee payments to the Kansas Department for Aging and Disability Services (KDADS) via Electronic Fund Transfer (EFT) or Automated Clearing House (ACH) in addition to paper check.
- ❖ Submission of this form will grant electronic payment access to the CRS platform for the specified users.
- ❖ This form can also be used to remove electronic payment access to CRS.
- ❖ Each facility is allowed to have as many users as it would like. However, a minimum of 2 and no more than 4 Users is recommended.

Submission Instructions:

- ❖ An Officer of the facility (e.g., CEO, COO, CFO) must complete and sign the below form, then email back to KDADS.
- ❖ For facilities under common ownership, a separate User Security Access Request form will need to be completed in its entirety for each facility.
- ❖ Each new or reinstating user must read, agree to the terms, and sign and date the appropriate fields below.
- ❖ Both written and electronic signatures are acceptable.
- ❖ Save this document as: Facility State ID, MM.DD.YY (ex. N012345 04.04.24).
 - State ID can be found on your facility's Adult Care Home license, and on the Facility Home Page screen after logging into KDADS' Web Applications:
<https://www.kdads.ks.gov/partners-providers/web-apps>
- ❖ Submit the completed form via e-mail to: KDADS.CollectionsRemittanceSystem@ks.gov

Facility Info, User Info, Attestation

Facility Name	
DBA	
State ID	City, State, Zip
Facility Address	Phone #
Main email	

User 1	
Type of Request	
Full Name	Title
Office Address	City, State, Zip
Main email	Phone #
User Signature	Date

User 2	
Type of Request	
Full Name	Title
Office Address	City, State, Zip
Main email	Phone #
User Signature	Date

User 3	
Type of Request	
Full Name	Title
Office Address	City, State, Zip
Main email	Phone #
User Signature	Date

User 4	
Type of Request	
Full Name	Title
Office Address	City, State, Zip
Main email	Phone #
User Signature	Date

I, the undersigned, am authorized to add and remove users for the Facility listed above. This authorization is to remain in force until the State of Kansas receives written notice of cancellation from me. I certify under penalty of perjury under the laws of the State of Kansas that the foregoing is true and correct. It is the responsibility of the Facility's Officer(s) to keep this information current.

Officer Signature _____

Date _____

Printed Name _____

Title _____