KDADS FMS Provider
Return of Excess Funds

Provider Name: _____

Provider Mailing Address: _____

City, State, Zip: _____

Medicaid Billing Number: _____

Provider NPI: _____

Telephone Number: _____

Agency Contact: _____

Time Period Reported: _____

Total DSW Funds Received: _____

Total DSW Funds Disbursed: _____

Total Excess Funds Enclosed: _____

Enclosed Check No: _____

I hereby certify under penalty of perjury that, to the best of my knowledge and belief, the information above is true and accurate. I further certify that all excess funds received for the reimbursement of Direct Service Workers for the years identified have been returned to the State of Kansas in accordance with K.A.R. 30-5-59. If the payment has not already been returned, all excess funds will be returned within 30 days of receipt of this request.

By: _____ Date: _____
Signature

Print Name: _____

Title: _____

Please attach additional supporting documentation.

Please make checks payable to the
Kansas Department for Aging and Disability Services
and remit to:
KDADS Accounting/Fiscal Services Manager
503 S. Kansas Ave
Topeka, KS 66603-3404