

P.O. Box 3599

Topeka, KS 66601-9738 Phone: 1-800-792-4884 Fax: 844-264-6285

Notification of HCBS Service: Referral/ Initial Eligibility/ Assessment/ Service Information

I. Consumer Information						
Name:			Ka	anCare ID #:		
Address:						
	SSN:			Date of Birtl		
Responsible Person/Contact:				Home Phon		
Address:		T.,		Work Phone		
Initiated By:		Name:			Date Sent:	
Reason for 3160:			нс	BS Program	Type:	
H HODO December 51'-11'11' to be formed by (5' to 1.51'-11'11' 11' 11' 11' 11' 11' 11' 11' 11						
II. HCBS Program Eligibility Information (Functional Eligibility				,		
Person Completing Section:			Office Phone:			
Address:				Office Fax:		
Applicant MCO choice:	Applicant Requesting PACE Referral			Referral:	Yes No	
HCBS Program Type:	Placed on Waiting List Yes No If yes, date:					
Program Threshold Met: Ye	s No	Services R	Requ	est Withdraw	n: Yes No	
Choose HCBS: Yes No If yes, Choice Date:						
Comments:						
Medicaid App in progress: Ye	s No	Assisted By:		If	Other:	
Person Completing Section:		7.100.0100 27.			Date:	
T craon completing occion.					Date.	
III. KDADS Program Manager Approval/Denial (I/DD ,PD, BI, AU, SED)						
Program Manager Approval Required: Yes No If yes, section must be completed by Program Manager						
Program Manager:	1			Office Phon		
HCBS Program Type: Approved Denied Effective date:						
Comments:						
Person Completing Section:					Date Sent:	
reison Completing Section.				Date Sent.		
IV MOO lesformention						
IV. MCO Information MCO: Estimated C	ant of Cara			Anticipato	d Start Data:	
MCO: Estimated Cost of Care: If transition, new address:				Anticipated Start Date:		
Comments:						
Comments.						
Person Completing Section: Date Sent:						
V. Eligibility Information						
Eligibility Worker:				Office Phone:		
Date application received:	Case number:			App status:		
Approval Type:				Effective date:		
Estimated Cost of care:	HCBS Client Obligation					
Next Review date:	HCBS Client Obligation				Month:	
Comments:						
Eligibility Worker: Date completed:						
Form Determined on an elimibility consulation to MOO. MDADO. A DOC						
Form Returned upon eligibility completion to MCO: KDADS: Assessor: DCF:						
August WEO NO						
Attachments: YES NO						