

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

I. Consumer Information			
Name:		KanCare ID #:	
Address:			
Phone:	SSN:	Date of Birth:	
Responsible Person/Contact:		Home Phone:	
Address:		Work Phone:	
Initiated By:		Name:	Date Sent:
Reason for 3160:		HCBS Program Type:	

II. HCBS Program Eligibility Information (Functional Eligibility Assessor)			
Person Completing Section:		Office Phone:	
Address:		Office Fax:	
Applicant MCO choice:	Applicant Requesting PACE Referral:		Yes No
HCBS Program Type:	Placed on Waiting List	Yes No	If yes, date:
Program Threshold Met:	Yes No	Services Request Withdrawn:	Yes No
Choose HCBS:	Yes No	If yes, Choice Date:	
Comments:			
Medicaid App in progress:	Yes No	Assisted By:	If Other:
Person Completing Section:			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:		Office Phone:	
HCBS Program Type:	Approved	Denied	Effective date:
Comments:			
Person Completing Section:			Date Sent:

IV. MCO Information		
MCO:	Estimated Cost of Care:	Anticipated Start Date:
If transition, new address:		
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:	Month:
Next Review date:	HCBS Client Obligation:	Month:
Comments:		
Eligibility Worker:		Date completed:

Form Returned upon eligibility completion to MCO:	KDADS:	Assessor:	DCF:
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Attachments: YES NO