Kansas
Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
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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: Choose	Name:	Date Sent:
Reason for 3160: Choose		**HCBS Program Type:** Choose

II. HCBS Program Eligibility Information (Functional Eligibility Assessor)			
Person Completing Section:		Office Phone:	
Address:		Office Fax:	
Applicant MCO choice: Choose	Applicant Requesting PACE Referral: ☐ Yes	☐ No	
HCBS Program Type: Choose	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Program Threshold Met: ☐ Yes ☐ No	Services Request Withdrawn: ☐ Yes	☐ No	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: Choose	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: Choose	◯ Approved ◯ Denied	Effective date:
Comments:		
Person Completing Section:		Date Sent:

IV. MCO Information		
MCO: Choose	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: Choose		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: ◯

Attachments: ☐ YES ☐ NO