Kansas Department of Health and Environment

NOTIFICATION OF KANCARE HCBS SERVICES
REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICE INFORMATION

ES-3160
01-19

I. CONSUMER INFORMATION

Name: _____ KanCare ID No.: _____
Address: _____
Phone: _____ SSN: _____ Date of Birth: _____
Responsible Person/Contact _____ Home Phone: _____
Address: _____ Work Phone: _____
Form 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Program Threshold Met: ☐Yes ☐No Services Request Withdrawn: ☐Yes ☐No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: _____

Signature Person Completing Section Date Sent

III. KDADS PROGRAM MANAGER APPROVAL/DENIAL (IDD/PD/TBI/Autism)

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: _____

Signature of Person Completing Section Date Sent

IV. MCO INFORMATION

MCO: Choose Estimated Cost of Care: _____ Anticipated Start Date: _____
If Transition, New Address: _____
Comments: _____

Signature of Person Completing Section Date Sent

V. ELIGIBILITY INFORMATION

Eligibility Worker: _____ Office Phone: _____
KanCare Application Received: _____ Case Number: _____ App. Status: Choose
Approval Type: Choose Effective Date: _____
Estimated Client Oblig.: _____ HCBS Client Obligation: _____ Month: _____
Next Review Date: _____ HCBS Client Obligation: _____ Month: _____
Comments: _____

Eligibility Worker Signature Date Complete

Form Returned upon eligibility completion to: ☐ MCO ☐ KDADS ☐ Assessor ☐ DCF

Attachments: ☐Yes ☐No